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ABSTRACT

This document consists of volume 7 of "The Prevention Researcher," a service of Integrated Research Services. Each issue provides information on a specific topic. The topic of Issue Number One is adolescent dating violence. This issue includes articles on adolescents' beliefs about rape and sexual victimization, and contains a report on an adolescent dating violence prevention project. Issue Number Two focuses on the topic of harm reduction. Harm reduction is a controversial approach to substance abuse that targets the consequences of drug use rather than its illegal or addictive status. Articles discuss the pros and cons of this approach. Issue Number Three is devoted to an understanding of inhalant use and the prevention of this toxic form of substance abuse. It presents background information and an understanding of the concerns professionals have about its use. Issue Number Four deals with self-injury, specifically cutting, burning, and otherwise harming one's body through self-inflicted wounds, a pervasive problem among teens. It contains information on how to help those who hurt themselves, how bulimia nervosa may be linked to impulse control disorders, and some reasons why youth engage in self-inflicted violence. The final issue is a supplement containing a cumulative topic index. (Author/JDM)

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GENDER AND CONTEXTUAL FACTORS IN ADOLESCENT DATING VIOLENCE

By Christian Molidor, Ph.D., Richard M. Tolman, Ph.D., and Jennifer Kober, MSW

In stark contrast to the image of dating as a time of intimate sharing and romantic experimentation, research indicates that dating is often a time of conflict and abuse, where partners become physical targets during emotional outbursts of anger, jealousy and confusion. While volumes of literature can be found regarding the substance and nature of adult intimate violence, research regarding interpersonal violence between adolescents has remained scarce. It hasn't been until very recently that an examination regarding the existence and meaning of dating violence in the high school population has been attempted. While some researchers have asserted that as many as one-third of high school youths are currently experiencing physical and sexual violence in their dating relationships, several recent studies of high school dating violence have shown that between 14.5% and 24.4% of female adolescents and 3.3% to 9.9% of male adolescents actually reported experiencing physical and/or sexual violence in their dating relationships. One study, which combined reported rates for boys and girls, found that 59% of male and female high school students reported experiencing at least one dating violence incident within the past year.

Between 14.5% and 24.4% of female adolescents and 3.3% to 9.9% of male adolescents actually reported experiencing physical and/or sexual violence in their dating relationships.

However, comparisons between rates of violence provide little information regarding critical aspects concerning the context and consequences of victimization. In order to explore the issue of high school dating violence in greater depth, we examined not only the rates of victimization for adolescent boys and girls, but we also looked beyond the reports of how frequently various types of violent acts occurred to what physical and emotional effects those acts had upon the victims, how the victims responded, and what effect the violence had on the dating relationship. We also explored when and where the violence occurred and who else was present. We felt that by examining these contextual issues, we would gain a better understanding of how violence differentially affects girls and boys.

Methods

Questionnaires were distributed to 635 students between the ages of thirteen and eighteen in 23 gym classes in a large midwestern high school. The gym classes were the only segregated classes the school could make available for research. However, we have no reason to believe that these classes differed in any systematic way from the rest of the school population. We believed

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FROM THE EDITOR'S PC

Dear Colleagues:

We are pleased to bring you this issue on the important topic of adolescent dating violence. Research by our first authors, Christian Molidor, Richard M. Tolman, and Jennifer Kober, has shown that for students between the ages 13–18 who had ever dated, 36% of the girls and 37% of the boys reported they had experienced physical violence in a dating relationship. Additionally, 42% or more of the boys and girls reported the worst abusive incident occurred in a school building or on school grounds.

Our second article, by Dr. Vangie Foshee and colleagues, discusses preliminary outcomes of The Safe Dates Project, *a school and community adolescent dating violence prevention project. Although partner violence often begins during adolescence this is the first study to evaluate the effectiveness of a partner violence prevention program for adolescents.*

These two articles are followed by a study by Ruth Kershner, Ed.D. on adolescents' beliefs about rape, and an article by Drs. Janine Zweig and Judith Vicary of The Urban Institute on sexual victimization. For more information and resources, we have provided several Web site addresses and reviews.

This is an exciting time for the staff at The Prevention Researcher. *I am happy to announce that we are moving into a quarterly cycle with our newsletter. Starting with this issue,* The Prevention Researcher *will be published each February, April, September and November. Additionally, we will continue producing our popular Resource Issue each December.*

In closing, I would like to thank Donna Scott Tilley, R.N., MSN, CRNH, for doing a guest Editorial Review of these articles. Additionally, I would like to invite you to explore our Web site (www.TPRonline.org) for references, abstracts of back issues, and other information about The Prevention Researcher.

All the best,

Steven Ungerleider, Ph.D.
Psychologist/Editor

that the accuracy of reporting of physical and sexual abuse would be enhanced by the privacy of the smaller, gender-specific classes. We also wanted to decrease the risk of perpetrator intimidation, both verbal and nonverbal, to victims while filling out their questionnaires. The measure of physical dating violence was a modified Conflict Tactics Scale (CTS). The CTS is the most commonly used instrument measuring intimate violence. In its initial form, it was used to measure how family members acted during conflicts. The modified scales were tested for internal consistency and found to be reliable. The questionnaire asked students to report on the frequencies of any past dating violence and in their most recent or current dating relationship. In addition to frequency of dating violence in past and current/most recent relationships, we examined the context of the occurrence of abusive acts in the current or most recent dating relationship.

Results

Males and females did not differ significantly according to overall frequency of violence in any past dating relationship. For students who had ever dated, 36.4% of the girls and 37.1% of the boys reported they had experienced physical violence in the dating relationship. When examining the rate of violence among all students who responded, rather than just those who dated, 31.3% of girls and 32.6% of boys experienced some physical violence in a dating relationship. These results, if viewed in isolation, paint a picture of boys and girls being equally violent.

TABLE 1

Experience of Violence in Current or Most Recent Dating Relationship

	Boys		Girls	
Item	N	%	N	%
Hair pulled	20	6.8	22	.7
Kicked	46	15.8	13	5.2**
Scratched	33	11.3	10	4.0**
Slapped	77	26.4	30	11.9**
Pinched	58	19.9	30	11.9*
Object thrown at you	27	9.2	31	12.3
Punched	16	5.5	44	17.4**
Forced sexual activity	1	.3	45	17.8**
Choked	10	3.4	16	6.3
Threatened with a weapon	9	3.1	7	2.8
Overall violence	111	38.1	90	34.9
Severe physical violence	38	13.1	58	22.5**
Moderate violence	109	32.9	63	21.0**

χ^2: *p<.05. **p<.01.

However, when examining levels of violence, from moderate to severe, a different understanding concerning the role gender plays in violence was uncovered. For violence in any dating relationship, girls, significantly more often than boys, reported that they experienced severe violence. Boys, on the other hand, were significantly more likely than girls to experience the less severe forms of physical dating violence.

There were no significant gender differences in rates of current dating violence. However, upon analysis, we discovered significant differences in the types of violence experienced. Girls were much more likely to be punched and to be forced to engage in sexual activity against their will. Boys on the other hand, were significantly more likely to be pinched, slapped, scratched, and kicked. In other words, girls experienced significantly more severe physical violence, while boys reported significantly more moderate physical violence.

In order to form a more complete understanding, consequences of the violence must also be examined. It stands to reason that since males and females experience different *types* of violence, they would also experience different emotional and physical *outcomes*. It is by factoring in this variable that the greatest disparity between male and female violence can be seen. When examining the worst incident of dating violence experienced in their dating relationship, boys reported no effect (did not hurt at all) or a little effect (hurt me a little) in over 90% of the incidents. The reports by girls differed markedly. When questioned about their worst experiences of dating violence, 47.8% of the girls reported serious harm (hurt me a lot) and physical injury (caused bruises, needed medical attention) in 33.6% of the incidents. They reported not being hurt at all in only 8.7% of incidents. Boys were significantly more likely to report little or no physical consequences of the violence they experienced.

The next step in the analysis was to examine the victims' reactions to the violence. Because an abused adolescent might have more than one reaction to a violent incident, the questionnaire asked them to note all their reactions to their worst incident of violence in their current or most recent dating relationship. Significant differences were found on several reactions to the violent incident.

TABLE 2

Physical Effects of Worst Incidence of Violence

	Boys		Girls	
	N	%	N	%
Did not hurt at all	59	56.2	8	8.7**
Hurt a little	36	34.3	18	19.6*
Hurt somewhat	7	6.7	9	9.8
Hurt a lot	4	3.8	44	47.8**
Caused bruises	3	2.9	27	29.3**
Needed medical attention	2	1.9	4	4.3

χ^2: *p<.05. **p<.01.

Over half of the boys reported "laughing" at the experience of a physical altercation while one third reported "ignoring it." Girls significantly more often reported having "fought back," having "tried to talk to their partner," or having "obeyed their partner" after experiencing violence. A critical distinction here is that 36% of the girls indicated they defended themselves when they experienced a violent act of their partner. This is one way of accounting for some of the incidents of violence that boys report occurring toward them. The boys' reports of violence toward them may in fact be their partners' acts of self-defense in reaction to violence they are experiencing.

An important contextual factor that also sheds light on the issue of self-defense relates to who initiated the violent incident. Girls reported their dating partners were the ones who started the abuse 70% of the time, while boys reported their dating partners to be the initiators of abuse only 27% of the time. The boys were much more likely to state that the incident was initiated by both of them.

Respondents also reported their perceptions of why the abuse occurred. For boys reporting they had been subject to a partner's use of physical violence, 17.1% reported that the reason for this violence was because they had been making sexual advances toward their dating partner. Only 3% of the girls reported that they were subject to violence as a result of their own sexual advances toward their partner. Further, the girls in the study reported they were victims of physical violence significantly more often while their male partners were making sexual advances. Thirty-seven percent of the girls reported the reason they were subject to physical violence was because their partner had been making sexual advances toward them, while only one male reported the same. This suggests that a large percentage of girls are being abused because they are refusing unwanted sexual advances. In addition, more boys (21%) than girls (10%) reported that their own jealousy was the reason for the violence expressed toward them. Finally, of the 117 boys who reported experiencing physical abuse, 36.8% reported they were drunk at the time of the violence. Only 9.4% of the girls reported they were drunk when they were hit. Fifty-five percent of the girls reported that their partners were drunk at the time of the incident.

To further understand victims' responses to the abuse, we asked students whom they told after their most abusive incident. There were no significant gender differences in who was told, however, less than 3% of the students reported the incident to an authority figure (e.g., police, counselor, or teacher). Only 6% of physically or sexually abused adolescents recounted the incident to a family member, 61% told a friend, and over 30% told no one at all.

Finally, students reported where the worst incident of abuse occurred and who was present during the incident. No significant gender differences were found. However, 42% of the males and 43.2% of the females reported the abusive incident occurred in a school building or on school grounds. In addition, while most of the abuse occurred while the couple was alone (60% of the time for girls, 51% for boys), either another boy or girl or a group of people were present 40% of the time when the female experienced abuse and 49% of the time when the male experienced abuse.

Discussion

Dating violence is clearly a significant problem for today's dating adolescent. While in our study, both boys and girls reported experiencing violence in their dating relationships, and significant differences were found in the severity of violence experienced and in the seriousness of the consequences

TABLE 3

Reaction to Worst Incident of Violence in a Dating Relationship

	Boys		Girls	
Reaction	N	%	N	%
I laughed	63	53.8	12	10.2**
I cried	3	2.6	47	40.2**
I ran away	1	.9	13	11.1**
I talked to partner	24	20.5	30	25.6
I fought back	15	12.8	42	35.9**
I obeyed	2	1.7	14	12.0**
I left scene	19	16.2	29	24.8
I ignored it	36	30.8	17	14.5**

χ^2: **p<.01.

experienced from the abuse. This leads us to believe that in regards to dating violence, gender differences are distinct, substantial, and severe.

Overall, the girls' reactions to the incidents of dating violence indicate that they are perceived as serious assaults having damaging physical and psychological effects. On the other hand, boys were much more likely to respond in ways that indicated the incidents were not perceived as threatening or damaging. For girls, the abuse was more likely to worsen or end the relationship. Boys perceived less negative impact of the abuse on their relationship, and were more likely to report that the relationship stayed the same or improved as a result of their partners' use of physical force toward them. It should be noted that while significant gender differences appeared, there was a small group of boys who reported that the violence they experienced did have significant negative consequences for them. Finally, our data strongly suggests that much of girls' violence toward boys may be the result of self-defense, either to fend off physical attacks or coercive sexual behavior.

42% of the males and 43.2% of the females reported the abusive incident occurred in a school building or on school grounds.

Implications for Intervention

These findings suggest numerous directions for intervention and prevention for dating violence. The literature on prevention of school violence generally has not addressed the issue of dating violence. Our study supports the contention that dating violence is a form of school violence. Not only are a large number of high school students likely to be victims of abuse by dating partners, but a high percentage of acts of abuse are occurring on the school grounds. While popular depictions might give the impression that school violence is largely a problem of violence between boys, these results demonstrate that the school is also a dangerous place for young women.

To address the issue, school systems need to create an environment of dating violence prevention by setting policies, developing intervention plans, and encouraging student input through classroom participation and workshops. Vital to this environment is the development of school policies that make the environment for victims safer by excluding known abusers from contact with their victims. This will send clear messages to all students that any type of violence within the school building or school grounds will not be tolerated and that authority figures are willing to listen and intervene if needed. Listening to students is crucial if adolescents are expected to talk to school personnel about abuse to get other help, something this study indicates they are very unlikely to do on their own. Our study revealed that only a few students contacted school personnel or any adult at all about the abuse they experienced.

Adolescents who experienced abuse were most likely to tell their peers, if they told anyone, suggesting that interventions must be directed toward preparing peers to respond effectively to abuse reported by their friends. Such preparation could include information about resources available to victims, so that peers might act as gateways to further help. However, peer responses that make it clear that abuse is unacceptable might deter perpetrators from further action, as well as supporting victim help-seeking. Given our results indicating that a substantial percentage of abusive incidents occur in the presence of peers, peer response that supports victims and confronts perpetrators is even more critical.

In addition to their reluctance to inform adults about abuse, help-seeking for adolescents abused in dating relationships is further complicated because adolescent victims of dating violence often do not have access to remedies available to adults, such as orders of protection, which most states do not issue for adolescent dating partners. However, the National Council of Juvenile and Family Court Judges recently introduced a model state domestic violence code that includes dating partners, including adolescents. While this action would create legal remedies for adolescent victims, adolescents pursuing such aid still face significant barriers. In order to seek these remedies, they will need to seek adult help, something our survey suggests they are very reluctant to do. Support for services to adolescent victims can be obtained from domestic violence programs, but many states do not permit adolescents to seek counseling for more than a few sessions before parental notification. Clearly linkages between such programs with adolescents through school-based programs are one strategy that could provide more effective gateways for service, including legal advocacy.

This study demonstrates that males may begin their abusive behavior toward female partners early in the life cycle. Attempts to change the batterer's behavior generally have focused on men later in the life cycle, typically when they become involved as adults in the criminal justice system. Even when male batterers come to the attention of the courts and intervention programs in their early twenties, they may already have a substantial history of gendered violence. Attempts to identify and intervene with violent boys as early as possible seem warranted. As adolescent girls increasingly seek help through the court system, the juvenile justice system must be prepared to effectively sanction adolescent batterers, and provide them with needed services. Programs designed for teen perpetrators must be available, either through programs currently serving adult batterers or through collaborations with teen serving agencies. Of course, prevention programs, which challenge male attitudes of entitlement to control and abuse of women, and which decrease social support for abusive male behavior, also are a critical element of a coordinated approach to ending dating violence.

Christian Molidor is an Associate Professor in the Graduate School of Social Work at the University of Denver. Richard Tolman is an Associate Professor at the University of Michigan School of Social Work. Jennifer Kober recently completed her MSW at the Graduate School of Social Work at the University of Denver and is currently working on her Ph.D.

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THE SAFE DATES PROJECT

By Vangie A. Foshee, Ph.D., Karl E. Bauman, Ph.D., Ximena B. Arriaga, Ph.D., Russell W. Helms, M.S., Gary G. Koch, Ph.D., and G. Fletcher Linder, Ph.D.

Partner violence burdens the health care system and the physical and mental health of individuals and family members. It is considered a major public health problem in the United States. Although partner violence often begins during adolescence, no prior study has evaluated the effectiveness of a partner violence prevention program for adolescents.

In this paper, we assess the effects of the Safe Dates project on the primary and secondary prevention of dating violence. Primary prevention is achieved when the first perpetration of dating violence is precluded. Secondary prevention occurs when victims stop being victimized or perpetrators stop being violent. We also evaluate the effects of the Safe Dates program on theoretically based mediating variables and whether the program prevents dating violence through these variables.

Safe Dates consists of school and community activities. School activities promote primary prevention, while school and community activities promote secondary prevention. School activities include (1) a theater production performed by peers, (2) a 10-session curriculum, and (3) a poster contest. Community activities include community service provider training and special services for adolescents in abusive relationships such as a crisis line, support groups, and materials for parents. All program components target theoretically based mediators and, hence, the behavioral outcomes (see Figure 1). School activities lead to the primary prevention of dating violence by (1) changing norms associated with partner violence, (2) decreasing gender stereotyping, and (3) improving conflict management skills. School activities lead to secondary prevention by changing those same variables and by changing beliefs about the need for help, awareness of services for victims and perpetrators of partner violence, and help-seeking behavior. Community activities enhance the availability of dating violence services from which adolescents can seek help. Studies indicate that both males and females are victims and prevention activities target both genders.

Methods

The study was conducted in a predominantly rural county in eastern North Carolina. The 14 public schools in the county with students in the eighth or ninth grade were stratified by grade and matched on school size. One member of each matched pair was then randomly assigned to a treatment or control condition. Students at treatment schools were exposed to school and community activities, and students at control schools were exposed to community activities only. Thus, we assessed the effect of the school activities over and above the effects of the community activities. Eighth and ninth graders were studied because we assumed that the topic would be salient for these children, many of whom were beginning to date. We also assumed that most of these children would not be involved in dating violence when they entered the study and would be appropriate targets for primary prevention, but that many would become involved during the study.

In October 1994, baseline data were collected from adolescents during 50-minute in-school sessions through self-administered questionnaires. Questionnaires were completed by 81% (n=1,886) of the 2,344 eligible adolescents.

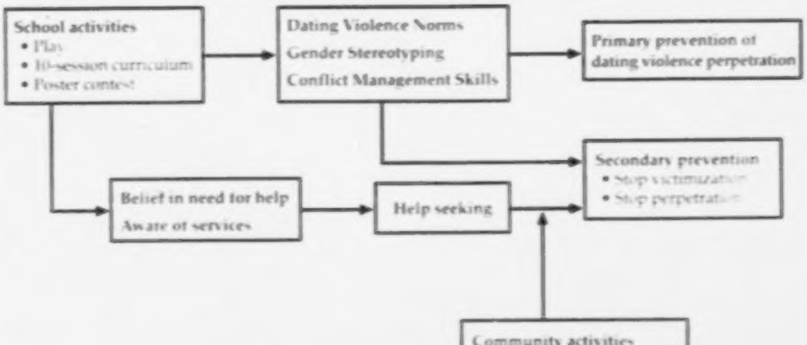
Program activities took place from November 1994 through March 1995. The play was performed at each of the seven treatment schools, and 97% of the students were present for the performances. The 16 teachers (10 men and 6 women) who taught required health courses in the treatment schools received 20 hours of training on teen dating violence and the Safe Dates curriculum prior to delivering the curriculum to their students in January and February 1995. Based on monitoring data, 90.7% of the intended curriculum activities were covered by the teachers. Classroom attendance in Safe Dates sessions ranged from 95.0% to 97.0%. The poster contest encouraged treatment school students to create posters on the prevention of dating violence. Although not all students created a poster, all were exposed to the messages in the posters because each student was required to vote for the best three in his or her school.

Twenty workshops were offered to community service providers, including social service, emergency room, mental health, crisis line, and health department staff, school counselors, sheriff's deputies, and officers from the nine police departments in the county. Approximately 63% of eligible service providers received the training. A weekly support group was offered to victims of partner violence.

Of the 1,886 adolescents completing baseline questionnaires in October 1994,

FIGURE 1

Safe Dates Theoretical Model



90% (n=1,700) completed questionnaires again in May 1995, one month after program activities ended. Of these 1,700 adolescents, 51.1% were female, 19.1% were African American, and 77.1% were White. Ages ranged from 11 to 17 years, with a mean of 13.8. At both baseline and first follow-up, about 70% of the adolescents reported dating. Of the adolescents who were dating at baseline, 34.9% of the girls and 38.0% of the boys reported being a victim of dating violence at least once.

Measures

Outcome variables. Four victimization and four perpetration variables were measured.

Psychological abuse victimization was measured by asking "How often has anyone that you have ever been on a date with done the following things to you?" Fourteen acts were listed, such as "damaged something that belonged to me" and "insulted me in front of others."

Partner violence often begins during adolescence.

Nonsexual violence victimization was measured by asking respondents "How many times has anyone that you have been on a date with done the following things to you? Only include when they did it to you first. In other words, don't count it if they did it to you in self-defense." Sixteen behaviors were listed, such as "slapped me," "kicked me," and "hit me with a fist."

Sexual violence victimization was measured, via the same base question used for nonsexual violence, with the two behavioral items "forced me to have sex" and "forced me to do other sexual things that I did not want to do."

Violence in the current relationship was measured. Adolescents were first asked whether they were currently dating someone. If so, they were then asked how often this partner had used physical force against them (not in self-defense) and how often they had used physical force against this partner (not in self-defense).

Mediating variables. Four variables measuring dating violence norms were created:

a) acceptance of prescribed norms (norms accepting dating violence under certain circumstances);
b) acceptance of proscribed norms (norms considering dating violence unacceptable under all circumstances);
c) perceived positive consequences of dating violence; and
d) perceived negative consequences of dating violence.

Gender stereotyping and beliefs in need for help were also assessed. As a means of measuring awareness of services, subjects were asked whether they knew of county services for victims and perpetrators of dating violence. As a means of measuring help-seeking, victims of dating violence were asked, "Have you ever asked anyone what you should do about the violence in your dating relationships?" Perpetrators were asked, "Have you ever asked anyone for help on how to stop using violence toward dates?"

Four conflict management variables were measured: constructive communication skills, destructive communication skills, constructive responses to anger, and destructive responses to anger. Communication skills were measured by asking, "During the last 6 months, when you had a disagreement with someone, how much of the time did you do the following things?" Items measuring constructive and destructive communication skills were used to create composite variables.

Responses to anger were measured by asking adolescents, "During the last 6 months, when you were angry at someone, how often did you do or feel the following things?" Items measuring constructive and destructive responses to anger were used to create composite variables.

The 1,700 subjects were divided into three subsamples based on dating violence experience. The primary prevention subsample included dating adolescents who reported at baseline that they had never been a victim or perpetrator of dating violence (n=862), the victim secondary prevention subsample included dating adolescents who reported at baseline that they had been a victim of dating violence (n=438), and the perpetrator secondary prevention subsample included dating adolescents who reported at baseline that they had been a perpetrator of dating violence (n=247). Consistent with other studies of dating violence, most of the adolescents in this study reporting experience with dating violence reported being both a victim and perpetrator. Thus, many of the same adolescents were in the victim and perpetrator subsamples. Sample sizes were too small to conduct analysis on subsamples of "pure perpetrators" and "pure victims."

Results and Discussion

Changes occurring in the full sample described the public health impact on the school activities. At follow-up, there was 25% less psychological abuse perpetration, 60% less sexual violence perpetration, and 60% less violence perpetrated against the current dating partner in treatment schools than in control schools. In addition, school activities had effects on several proposed mediating variables, the largest differences being in dating violence norms, gender stereotyping, and awareness of services, the variables targeted most heavily by school activities. Mediation analysis suggest that effects of the school activities on partner violence perpetration occurred primarily through changes in these three variables.

Both primary and secondary prevention effects were observed. In the primary prevention sample, there was 28% less psychological abuse initiated in treatment than in control schools. Psychological abuse often precedes physical violence; thus, preventing psychological abuse may be the first step toward preventing violent behaviors. There was 27% less psychological abuse perpetration and 61% less sexual violence perpetration reported at follow-up by dating violence perpetrators in treatment than in control schools. These effects were obtained by changes in the perceptions of negative consequences of dating violence and by an increase in perpetrators' awareness of services.

One goal of secondary prevention was to encourage victims and perpetrators to seek help. Although victims and perpetrators in the treatment group became significantly more aware of services than those in the control condition, there were no between-group differences in help seeking. Help seeking increased substantially from baseline to follow-up in both conditions. Still, a minority of victims (35%) and perpetrators (34%) reported seeking help from anyone, and these adolescents sought help from friends and parents rather than from community service providers.

Exposure to school activities did not increase the likelihood that victims would stop being victimized. One explanation for this is that many study adolescents were dating people who were not in the sample. For example, 75% of the girls were dating partners in the older grades than the study sample, and 75% of the boys dated partners in younger grades than the study sample. Therefore, it is likely that a significant portion of the victims were being victimized by partners who were not in the study and therefore not exposed to the intervention. Another explanation is that the program failed in that area.

There are several explanations for the study findings. One is that the Safe Dates school activities caused the changes that were detected in the outcome and mediating variables. Another is that adolescents exposed to these activities were more likely to give socially desirable answers at follow-up than adolescents not exposed to them. The socially desirable response is apparent for outcome variables but less apparent for many of the mediating variables. For example, the socially desirable responses to items such as "Bad things happen to people who are violent to their dating partners," "Boys sometimes deserve to be hit by the girls they date," and, "It is OK for a girl to hit a boy if he hit her first" are not particularly apparent. The same is true of responses to awareness of services items such as "Are there services in the county for helping victims of dating violence?" Yet, treatment effects were still observed in these variables.

> *Although the number of youth violence prevention programs offered in our communities has increased, most of these programs do not address the unique issues related to dating violence.*

Adolescents exposed to school activities may have redefined abuse more narrowly, influencing their reporting of behaviors at follow-up but not their actual behaviors. For example, at baseline, when asked to report violence "ever" perpetrated, an adolescent may have included shoving a dating partner. At follow-up, when asked the same question, the adolescent may not have included the shove because it had been a playful gesture toward the partner, realizing, through program exposure, that this was not the type of behavior being assessed by the questionnaire. This explanation for program effects seems unlikely because both treatment and control group perpetrators reported less "ever" use of dating violence at follow-up than at baseline. The perpetrator subsample was defined according to extreme scores of dating violence. It appears that follow-up scores regressed to the mean in both the control and treatment groups.

Because of the timing of the follow-up data collection and the way dating violence was measured, program effects were probably underestimated. Follow-up data were collected one month after program activities, and thus there was not much time for behavior change. Also, when adolescents answered follow-up questions about "lifetime" involvement in dating violence, they were reporting new violence occurring between baseline (October) and follow-up (May). Much of what was reported may have occurred before the program was completed. Therefore, our follow-up measure is not as pure as desired. As a means of addressing these limitations, one-year follow-up data were collected, and are currently being evaluated. In this follow-up data subjects were asked to report violent and abusive behaviors experienced during the prior year.

Although the number of youth violence prevention programs offered in our communities has increased, most of these programs do not address the unique issues related to dating violence. Given that partner violence is one of the most significant public health problems and that it often begins during adolescence, youth violence prevention efforts should include activities for preventing this specific form of violence and be evaluated for effectiveness. Through evaluation, the Safe Dates school activities show promise for preventing adolescent dating violence and, therefore, potential for public health impact.

Dr. Vangie Foshee is an Associate Professor in the Department of Health Behavior and Health Education from the School of Public Health at the University of North Carolina at Chapel Hill. Her research focus is on adolescent problem behaviors. Dr. Karl Bauman is professor in the Department of Health Behavior and Health Education of the School of Public Health at the University of North Carolina at Chapel Hill, and senior research analyst at Research Triangle Institute, Research Triangle Park, North Carolina. Dr. Ximena Arriaga is currently an Assistant Professor in Psychological Sciences at Purdue University. Russell Helms is a Ph.D. candidate in the Department of Biostatistics at the University of North Carolina at Chapel Hill. Dr. Gary G. Koch is Professor of Biostatistics and Director of the Biometric Consulting Laboratory at the University of North Carolina at Chapel Hill. Dr. G. Fletcher Linder is an anthropologist whose interests lie in how historical processes shape how we understand, experience, and act in the world, particularly with regard to notions of gender, sexuality, and self discipline.

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ADOLESCENTS' BELIEFS ABOUT RAPE: A PRELIMINARY STUDY

By Ruth Kershner, RN, CHES, Ed.D.

Many people are aware that violence against women is rampant in our society. What they often do not realize is the prevalence of rape among young women. Numerous studies have found that adolescent girls between the ages of 12 and 19 are at risk, not only for stranger rape, but also for rape that occurs within the context of dating.

Law enforcement agencies estimate that fewer than 35% of stranger rapes and only 13% of acquaintance rapes are reported in the United States, which leads the world as the most rape-prone country. Young women are the least likely to contact law enforcement about rape victimization. Recent governmental studies have indicated that 11% of female rape victims were between the ages of 12 and 15, while 25% were between 16 and 19. These numbers are believed to be just the tip of the iceberg. Research studies mirror governmental findings. Study after study has demonstrated the vulnerability of adolescent girls to rape. Even young males have reported being victimized.

> *Studies with adolescents indicate that young people subscribe to a belief in male dominance and tend to perceive women as sexual objects.*

Increasingly, young adolescent males are being arrested as perpetrators of rape. Males between 12 and 20 were involved in 17% of single-offender rapes, which are defined as one victim/ one offender. Thirty percent of multiple-offender rapes, which are defined as two or more offenders per victim, are committed by males 20 years of age or younger. The greatest increase in arrested rape offenders involves adolescent males.

A limited number of studies specific to adolescents and rape beliefs are found in the literature. Much of what is known comes from college-age students. Many young adults are not aware of what constitutes sexually coercive behavior. This is especially apparent when rape occurs between acquaintances or during a date.

An analysis of studies that have been conducted with adolescents regarding rape reveals some illuminating findings. Both young males and females consider forced intercourse acceptable in certain situations, and are not immune to conservative attitudes[1] about rape. Some researchers have found a correlation between conservative attitudes about gender roles and victim-blaming in rape cases, a finding that often holds true in the adult population as well. Other studies with adolescents indicate that young people subscribe to a belief in male dominance and tend to perceive women as sexual objects.

Methods

This study was initiated to evaluate adolescent beliefs about rape and to develop curricular materials from the findings for a rape prevention educational program. Prior to the development of the survey, a literature review was conducted. Sixty-five items were extrapolated from the literature for possible use in the survey. A group of parents evaluated the items for offensive or questionable terminology. Four adolescents, ages 12 to 17, assessed the items for readability.

The original item pool was circulated to a review panel consisting of school health teachers, rape crisis center coordinators, school counselors, and a physician who works with rape victims in the emergency room. The judges were asked to review the items for content, clarity, readability, and appropriateness for the adolescent population. After revision, the survey instrument was scaled down to 25 items.

Consent and assent forms were distributed to 154 parents and students (ages 14 to 19) in a rural high school in northern West Virginia. The survey was administered to six health education classes and 122 participants completed the questionnaires.

Results

One item in the survey instrument was eliminated because of correlation problems. Statistical testing of the instrument indicated good internal consistency. Responses to the survey ranged from one to five, with a higher score indicative of a less conservative attitude about rape. A certain amount of ambivalence can be assumed for items with a score of less than four.

While students were not uncomfortable with the notion of girls asking boys out on dates, ideas about relationship control and gender roles are not so clearcut (see Table A). Students were found to adhere to common rape myths including those pertaining to stranger rape, male rape victimization, sexual needs of rapists, and pregnancy and rape. Most conservative beliefs were related to female dress, rape fantasy by females, and rape provocation. The respondents were also found to have misconceptions about rape victims in court proceedings and the rape reaction process suffered by victims of sexual assault.

Discussion

It is apparent that adolescents are in need of rape prevention education that encompasses the sociocultural aspects that contribute to rape. The best way to decrease the incidence of rape victimization is through education that begins early and is reinforced sequentially throughout the formative years. In this way students may learn to adopt egalitarian belief systems that may decrease the incidence of the crime of rape. ❧

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[1] "Conservative attitudes" refers to conservatively held attitudes about the "roles" of men and women in society. Research has shown that those with more rigid perspectives about gender roles are more likely to blame women for their rape victimization and less likely to blame men for being perpetrators.

Ruth Kershner is an Assistant Professor in the Department of Community Medicine, West Virginia University School of Medicine. She teaches primarily in the area of School Health and is nationally credentialed as a Health Education Specialist. This article is condensed from Ruth Kershner, (1996). Adolescent Attitudes About Rape. Adolescence, Vol 31(121), 29-33. *It appears here with permission from the publisher, Libra Publishers, Inc.*

TABLE-A

Item	Strongly Disagree/ Disagree	Undecided	Strongly Agree/ Agree	Mean
1. Generally, women should not be out alone at night	22%	30%	48%	2.70
2. Rapists usually have a history of criminal behavior	65%	31%	4%	4.00
3. Rapists have a greater need for sex than other people	54%	24%	22%	3.52
4. Women are often portrayed as sex objects in the media*	22%	30%	48%	2.72
5. The main role of a wife is to take care of her husband	39%	20%	42%	2.98
6. Most women fantasize about being raped by a man	15%	33%	52%	2.52
7. It is easier for a married woman to get over being raped than it is for a single woman	22%	29%	50%	2.72
8. Stranger rape is a more serious crime than date rape	54%	29%	17%	3.67
9. A rape victim should actively resist throughout an attack	15%	30%	55%	2.49
10. Raping a virgin is more serious than raping someone who is not a virgin	57%	33%	10%	3.72
11. In most cases, the rape victim shares some of the responsibility for the attack	65%	25%	10%	3.88
12. Some girls encourage rape just by the way they dress	27%	27%	46%	2.87
13. The best way to get over being raped is to avoid thinking about it	13%	42%	45%	2.63
14. A woman will fight off a man if she really wants to avoid being raped	86%	8%	6%	4.30
15. A victim's sexual history should not be made public during a rape trial*	18%	50%	33%	2.82
16. It is easier to believe a physically injured rape victim than one who has no injuries	79%	14%	7%	4.11
17. The victim should be required to prove his/her innocence during a rape trial	32%	34%	35%	3.03
18. The best relationships are those in which a man is in control	59%	29%	12%	3.62
19. Many girls falsely report rape if they are facing an unwanted pregnancy	42%	27%	31%	3.23
20. Strong men do not cry	63%	16%	21%	3.57
21. Victims of rape react in a similar manner	49%	43%	9%	3.58
22. Girls should not ask boys out on dates	77%	19%	4%	4.29
23. Some women provoke men into raping them	26%	22%	53%	2.63
24. Most men who are raped are gay	62%	21%	17%	3.77

Responses range from one to five with a higher score (disagree) indicative of a less conservative attitude about rape, except for #4 and #15.

Some percentages exceed 100 because of rounding.

* reverse scored.

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RESOURCES

Eastside Domestic Violence Program
http://www.eastside.net/edvp/

This site is maintained by a non-profit domestic violence program in Washington state. While mostly concerned with domestic violence among adult women, it does contain information about teen dating violence. The site is easy to read and informative. Included are reasons why an adolescent might stay with an abusive partner, special issues for youth (including the fear of pregnancy and the effect of pregnancy on abusive relationships, race and culture, gay/lesbian youth), characteristics of adolescent dating violence, and ideas for helping others in violent relationships or getting help for yourself.

Love Doesn't Have to Hurt
http://www.apa.org/pi/pii/teen/

This site is designed for teens and includes such topics as, "Sound Familiar?," which offers scenarios of various types of dating violence, "Why Does it Happen?," resources, and helpful suggestions. Varying cultural beliefs, gay/lesbian relationships, the effects of alcohol and drugs, getting sexually involved with an adult, and violence at home are also discussed. This is a visually attractive, quick to load, and easy to read resource for boys and girls, whether they are victims, perpetrators, or concerned friends. *Love Doesn't Have To Hurt* is offered by the American Psychological Association with the consultation of Partners in Program Planning in Adolescent Health (PIPPAH).

National Center for Injury Prevention and Control
http://www.cdc.gov/ncipc/

The National Center for Injury Prevention and Control Web site contains several documents about dating violence including brief facts about the problem and characteristics of the perpetrator. Descriptions of currently funded Intimate Partner Violence Prevention projects aimed at youth are included with contact information.

National Coalition Against Sexual Assault
http://www.ncasa.org/

Not geared specifically toward adolescents, the National Coalition Against Sexual Assault provides several articles about sexual assault, addresses myths and facts, addresses the problem of male sexual assault, and gives a nice set of links to related sites.

National Crime Prevention Council On-Line Resource Center
http://www.ncpc.org/

The National Crime Prevention Council Web site includes information on both dating violence and date rape among its crime prevention resources. Information is organized by target group and dissemination plans (teens, neighborhoods, program ideas, local initiatives) instead of topic (dating violence, vandalism). While visually attractive, we found navigation around this site troublesome. However, with the search engine we were able to find several good articles and reports on dating violence and date rape. Information is also available in Spanish.

Rape, Abuse and Incest National Network (RAINN)
http://www.rainn.org/

RAINN is a non-profit organization which operates a national hotline for survivors of sexual assault. The hotline, 1-800-656-HOPE, offers free, confidential counseling and support 24 hours a day, from anywhere in the U.S., for survivors who cannot reach a rape crisis center through a local call. According to the Web site, when a survivor calls the 800 number, a computer identifies the caller's location by reading the area code and the first three digits of the phone number. Then instantaneously connects the caller to the nearest rape crisis center. The caller's complete phone number is not captured, so every call is confidential. This service is extremely helpful for people who cannot make a toll call to a crisis center for fear it will show up on the phone bill. Additionally, the Web site provides a listing of crisis centers by state and a list of facts about sexual assault.

Sexual Assault Information Page (SAIP)
http://www.cs.utk.edu/~bartley/saInfoPage.html

The Sexual Assault Information Page is an excellent starting point for finding more on the Web. It is brimming full of links to resources on topics such as date rape, prevention, incest, sexual harassment and others. SAIP is the most linked-to site we found in our search on the Web.

Trust Betrayed
http://wvbph.marshall.edu/trust/trust-to.htm

A combined effort of several West Virginian groups, the Trust Betrayed Web site includes a lot of information in an easy to read format. Warning signs, common myths about relationships, a "respect meter," tips on avoiding bad relationships, and examples of how a partner tries to gain power and control in a dating relationship are just a few of the topic headings on this Web site.

When Love Hurts: A guide for girls on love, respect and abuse in relationships
http://home.vicnet.net.au/~girlsown/

An attractive space designed for girls, this Web site includes information about what is considered abuse in a relationship, why it occurs, warning signs, how to help a friend or family member, a "thinking sheet" to help girls examine their own relationship, information about breaking up, and safety. Interspersed are real-life stories from other girls. This is an excellent resource for girls. A text-only option is available.

SEXUAL VICTIMIZATION DURING ADOLESCENCE AND YOUNG ADULTHOOD

By Janine M. Zweig, Ph.D. and Judith R. Vicary, Ph.D.

Childhood sexual abuse and adult rape experiences are what we usually think of first when discussing sexual violence. However, large numbers of adolescents experience sexual violence. In fact, the ages at which women are most vulnerable to sexual victimization are the adolescent and young adult years. Studies by Baier, Rosenzweig, and Whipple as well as Erickson and Rapkin have shown between 12 to 20% of women have experienced sexual victimization, including rape, during adolescence or young adulthood.

A great deal is known about the prevalence of sexual victimization of young women, as well as the characteristics of victims and their perpetrators. It is clear that most victims of sexual violence are female and most perpetrators are male. The majority of adolescents who are the earliest to initiate sexual intercourse have had coercive sexual experiences, and women who were victimized as children or adolescents are much more likely than other women to be victimized again in adulthood. Most victims at least know their perpetrators and many are even involved in romantic relationships with those individuals who ultimately violate them. We also know that victimization most often does not occur in the streets or in alleys, but in familiar places, such as victims' homes. Despite the media and academic focus on victimization of college students, research by Zweig, Barber, and Eccles has shown that women who do not attend college may actually experience rape and sexual abuse in greater numbers than women who do attend college. And finally, we know that despite the focus on victimization in urban areas, many rural women experience, and must cope with, sexual violence as well.

The negative effects of sexual violence have been widely documented. Following victimization experiences women (and men) who experience victimization have poorer social and psychological adjustment than individuals who do not have these experiences. It is also clear that the type of victimization that a woman experiences and the nature of the relationship between the woman and her perpetrator have further implications for women's adjustment. Adjustment problems occur for women when their victimization experience includes the threat or use of physical violence or if the experience includes psychological manipulation. Also, the more closely tied women are to their perpetrators, particularly if the perpetrators are someone the women love and trust, the more negative the experiences.

Given the frequency of sexual violence and its negative consequences, it is important to further examine the risk factors associated with such experiences. Many prevention researchers hesitate to examine risk factors for victimization because of their fear that it embraces a "blame the victim" model. However, some circumstances or situations can increase a woman's vulnerability to victimization so that knowing what puts women at risk may help in developing appropriate prevention strategies to address those risks. It is also important to identify what puts males at risk for perpetrating sexual violence. While preventing perpetration is key to preventing sexual violence, it's beyond the scope of the current discussion.

> *The ages at which women are most vulnerable to sexual victimization are the adolescent and young adult years.*

Research concerning the risk factors associated with sexual victimization includes analysis of contextual or demographic factors, individual behaviors of victims, and psychological adjustment of victims. As noted earlier, there are some unchangeable characteristics, such as gender and age. Other factors that are difficult to address include increased risk related to earlier childhood and adolescent victimization experiences and the woman's socioeconomic status.

A number of studies have identified individual behaviors and aspects of psychological status that increase women's vulnerability to experiencing sexual victimization. These include frequency of sexual activity, number of sexual partners, substance use, and lower mood quality. (Mood quality is a measure of feelings of happiness, anxiety, and depression. Lower mood quality refers to less feelings of happiness along with more feelings of anxiety and depression, as compared to other youth in the sample.) These studies have found relationships between individual behaviors and affective status and the increased likelihood of experiencing victimization. In Vicary's longitudinal work, a relationship was found between lower mood quality and an increased likelihood of experiencing dating violence and rape. It was also found that the relationship between individual behavior and the likelihood of experiencing sexual victimization is influenced by larger demographic characteristics as well. Specifically, higher frequency of sexual behavior is related to increased vulnerability for experiencing physically violent sexual experiences (i.e., experiences including the threat or actual use of physical violence) only for women from lower socioeconomic backgrounds. However, higher frequency of sexual behavior is related to increased vulnerability for experiencing coerced sexual experiences (i.e., experiences including psychological manipulation or alcohol/drug use) for women from all socioeconomic groups.

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The above findings suggest important issues that require further examination. First, risk factors for sexual victimization may vary based on both the demographic and contextual characteristics of women's lives. A particular behavior or circumstance may or may not place women at an increased risk for victimization depending on larger societal characteristics. Second, the predictive ability of risk factors varies based on the types of sexual victimization experienced. Just as the consequences of sexual victimization vary based on the nature of the experience, so too do the risk factors vary. Certain risk factors may increase a woman's vulnerability to physically violent sexual experiences while other factors may increase her vulnerability to more psychologically manipulative experiences or experiences involving substance abuse.

As researchers further explore the variables associated with sexual victimization and address the two issues highlighted above, we will be better able to develop prevention strategies. These efforts should be targeted toward both females and males and, at a minimum, can include education about the nature of sexual victimization, as well as what types of situations or behaviors may increase vulnerability to such experiences. In addition, prevention strategies that address skills to thwart psychologically manipulative tactics may also be useful.

Although a number of adolescents and young adults do experience sexual victimization and many have these experiences within the boundaries of romantic relationships, the message to adolescents and their families should not be to stop dating or experiencing romantic relationships. Instead, we should provide youth, both males and females, with opportunities and abilities to create healthy friendships, as well as loving and respectful romantic relationships.

Janine M. Zweig, Ph.D., is a Research Associate at The Urban Institute. Her research has focused on the risk factors and consequences of sexual victimization and she is involved in evaluating the programs funded through the Violence Against Women Act of 1994.

Judith R. Vicary, Ph.D., is a Professor of Biobehavioral Health at The Pennsylvania State University and a senior research fellow at the Robert Wood Johnson Foundation. She has conducted prevention research addressing antecedents and consequences of teen pregnancy and adolescent and young adult substance abuse.

COMING IN FUTURE ISSUES

HARM REDUCTION

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YOUTH SELF-INJURY

GAY, LESBIAN, & BISEXUAL STUDENTS

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HARM REDUCTION: BASIC PRINCIPLES AND STRATEGIES

By G. Alan Marlatt, Ph.D.

American views of drug use and addiction have been based on two competing and sometimes conflicting models: the moral model and the disease model. In terms of the moral model, American drug control policy has determined that illegal drug use and/or distribution of drugs is a crime deserving of punishment. The majority of federal funding earmarked for drug controls has been granted to law enforcement agencies whose programs are born out of a "supply reduction" approach. These programs not only seek to reduce the supply of drugs coming into the country from the outside, but also to stem the production, sales, and use from within.

The second approach is to define addiction (e.g., alcoholism or heroin addiction) as a biological/genetic disease that requires treatment. Here the emphasis is on prevention and rehabilitation programs that focus on remediation of the individual's desire or demand for drugs, a "demand reduction" approach. Despite the apparent contradiction between viewing the drug user as either a willful criminal or as a hapless victim of biology, the aim of both the supply and demand reduction models is to reduce, and eventually eliminate, drug use by focusing primarily on the drug user ("use reduction").

> *Supporters of harm reduction shift the focus away from drug use itself to the consequences or effects of addictive behavior.*

Harm reduction, with its philosophical roots in pragmatism and its compatibility with a public health approach, offers a practical alternative to either the moral or disease models. Supporters of harm reduction shift the focus away from drug use itself to the consequences or effects of addictive behavior. Such effects are evaluated primarily in terms of whether they are harmful or helpful to the drug user and to the larger society.

Abstinence and Reduced Harm

The moral model and the disease model also share a common value: the insistence upon total abstinence as the only acceptable goal of either incarceration or treatment. Most chemical dependency treatment programs refuse to admit patients who are still using drugs. That one must first abstain in order to receive treatment designed to maintain abstinence exemplifies a "high threshold" approach that often presents a barrier to those seeking help.

Absolute abstinence is also emphasized as the only acceptable goal of prevention and treatment by those who subscribe to the disease model of addiction. From this perspective, addiction is viewed as a progressive disease that cannot be cured, but only "arrested" by a lifelong commitment to abstinence. Any subsequent drug use is defined as a relapse back into the disease condition, an inevitable outcome determined by biological factors beyond the individual's control.

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FROM THE EDITOR'S PC

Dear Prevention Colleagues:

I want to welcome all of you to our Spring issue. This issue is on a topic that is not well covered in the prevention arena, harm reduction. Harm reduction is a controversial approach that focuses on the consequences of drug use as opposed to its illegal or addictive status. It is so controversial, in fact, that many government-funded programs are prohibited from using it.

Our guest authors are a fine group of professionals who cover harm reduction from several perspectives. Dr. G. Alan Marlatt, director of the Addictive Behaviors Research Center at the University of Washington, starts off this issue with an introduction to the basic principals of harm reduction. Drs. Diane Riley and Pat O'Hare of the International Harm Reduction Association discuss how harm reduction is practiced. Dr. Michael Clatts of the National Development Research Institute in New York City, Edith Springer with the Harm Reduction Coalition, and colleagues show us harm reduction at work with street youth in New York City.

Once you've read these articles, I invite you to the discussion board on our Web site to explore the topic of harm reduction with your colleagues.

We would also like to welcome Ms. Faedra Lazar Weiss, M.A.H.L., research associate at Girls Inc., to our editorial board. Ms. Weiss has been very active with The Prevention Researcher *and we are delighted to add her to our editorial board.*

As always, I invite you to check out our Web site at www.TPRonline.org for more prevention information.

All the best,

Steven Ungerleider, Ph.D.
Psychologist/Editor

Harm reduction is **not** anti-abstinence. Harmful effects of unsafe drug use or sexual activity can be placed along a continuum. Abstinence is included as an ideal end-point along a continuum that ranges from excessively harmful to less harmful consequences. By placing the harmful effects of drug use or sexual behavior along a continuum, supporters of harm reduction encourage any movement toward decreased harm as steps in the right direction.

A Grassroots Method

In the Netherlands, needle-exchange programs for IV drug users began in response to input from addicts who belonged to the "Junkiebond" group and who advocated for drug policy changes that would permit the legal exchange of needles in order to reduce the risk of HIV infection. Many other harm reduction projects have also originated at the local level, often promoted by those directly involved in receiving and providing services.

> *Advocates of harm reduction are willing to reduce barriers to treatment, thereby making it easier to get started.*

Addiction and AIDS are problems that are so plagued with stigma and tainted with moral condemnation that individuals who suffer from these twin problems are often marginalized by society. Unlike other disorders such as cancer or mental illness, in which those who are afflicted or affected have formed powerful lobbying groups and "patient advocacy" societies (e.g., the American Cancer Society), it is rare to find parallel advocacy groups in the addictions field. Although the gay community has rallied in support of advocating better prevention (e.g., safe sex programs) and treatment services for those who are HIV positive, until recently, the community of IV drug users in the U.S. has had little or no impact on the provision of services for addicts.

The impetus for harm reduction programs has not come from the "top down"—neither the White House Office on National Drug Policy nor the National Institute of Drug Abuse has promoted or supported harm reduction as a national drug policy. If anything, these approaches have been denigrated and criticized at the federal level.

Low-Threshold Access to Services

Advocates of harm reduction are willing to reduce barriers to treatment, thereby making it easier to get started. Low-threshold programs do this by several means: by reaching out and achieving cooperation with the population in need in developing new programs and services; by reducing stigma associated with getting help for these kind of problems; and by providing an integrative, normalized approach to high-risk substance use and sexual practices.

Supporters of a low-threshold approach are willing to meet the individual on his or her own terms, to "meet you where you are" rather than "where you should be." Through dialogue, discussion and mutual planning efforts, innovative outreach programs and associated services will continue to emerge at the community level. Those affected are accepted as partners who are capable of assuming responsibility for making personal changes in their behavior and helping others to do the same.

A second component of a low-threshold approach involves reducing the stigma associated with problems of addiction, substance abuse, and high-risk sexual practices. How can this stigma be reduced? In a review of the literature, it was found that the primary factor that motivates people to seek treatment is their personal experience of the problematic consequences of using drugs. As such, problems in personal health, finances, and family and relationship difficulties become the focus for help-seeking, rather than identifying "substance abuse" itself as the problem. By switching the focus to reducing the harm associated with drug use or high-risk sex, and away from labeling the problem as one of addiction or deviance, prospective help-seekers are more likely to come "out of the shadows" and seek assistance.

The third aspect of a low-threshold approach is the capacity for harm reduction to embrace and consolidate a variety of behaviors that span substance use and high-risk sexual behaviors. Drug use is rarely independent of other high-risk behaviors such as unsafe sexual practices and driving under the influence. With a common focus on the harm such behaviors cause, doors can be opened that are currently locked by stigma and shame.

Harm reduction defines much drug use and other addictive behaviors as maladaptive coping responses. A comprehensive, low-threshold approach is designed to promote the development of more adaptive coping mechanisms. Such problems are best conceptualized within an integrative, holistic perspective that views drug use and/or high-risk sexual behaviors as interdependent and reciprocally interactive components of personal lifestyle. By adopting a comprehensive health-promotion response to lifestyle problems that includes substance use, sexual practices, exercise, nutrition, and other personal and interpersonal habits (both helpful and harmful), harm reduction can offer an attractive low-threshold gateway to welcome anyone.

Compassionate Pragmatism vs. Moralistic Idealism

As a pragmatic approach, harm reduction accepts that harmful behavior happens—it always has and it always will. Once this premise is accepted, the goal becomes one of compassionate pragmatism. Pragmatism is concerned with the management of everyday affairs and actual practices, and its validity is assessed by practical results.

Harm reduction accepts the fact that some people have always used drugs and will continue to do so, just as some people will continue to engage in high-risk sexual behaviors. Rather than labeling the person who engages in such behaviors as good or bad, harm reduction asks the question: To what extent are the consequences of this individual's behaviors harmful or helpful to the individual and to others who may be affected?

As an approach based on acceptance and compassion, harm reduction has parallels with other philosophies and schools of therapy. Harm reduction adopts a humane approach to dealing with human suffering, a stance that is similar to humanistic psychology as espoused by Carl Rogers, Abraham Maslow, and others. Maslow described a hierarchy of human needs, with basic survival needs (food, shelter) as the base; one cannot begin to work with an individual's higher needs (psychological, social, and spiritual) until basic needs have been met. The "client-centered" approach favored by Rogers is consistent with harm reduction's emphasis on establishing a partnership between clients and providers in which the client's needs come first in developing programs or services.

Procedures and Strategies

In describing the methods and procedures of harm reduction, three basic strategies arise: working with the individual or group, modifying the environment, and implementing public policy changes.

Implementing Harm Reduction with Individuals and Groups

Harm reduction practices can be taught in educational programs designed to help people reduce the risk of engaging in such high-risk behaviors as drinking, smoking, overeating, using licit and illicit drugs, and sexual activities. The goal of such training is the prevention of harm.

Programs based on harm reduction are designed to accommodate those who have already "said yes" to experimenting with drugs and sex.

In working with individuals, alone or in groups, **education** is the key to the prevention and minimization of harm related to high-risk drug use and sexual behavior. Unlike prevention programs for youth that focus exclusively on abstinence and promote zero tolerance, programs based on harm reduction are designed to accommodate those who have already "said yes" to experimenting with drugs and sex. Such programs can be structured in group settings to include discussion of **both** abstinence and drug use or sexual activity. The decision to become active or to remain abstinent can be informed by a discussion of the relative pros and cons of each choice.

Educational prevention programs based on a harm reduction model share several common elements. Input from participants (e.g., students) is sought when programs are first developed. In harm reduction education, the program format is similarly interactive, with active discussion encouraged throughout. Information is exchanged on an interpersonal basis, and "lectures" by experts are avoided. Active role-plays are used to practice coping skills and rehearse what to do in high-risk situations. Alcohol and drug use can be integrated into discussions of sexual activity rather than dealt with as separate, unrelated topics. A strong emphasis is placed on personal choice and responsibility.

The overall goals of harm reduction based prevention programs include: enhancing awareness of high-risk behaviors and their consequences (both helpful or harmful), training in coping skills to deal effectively with high-risk situations involving drugs or sex, and facilitating health-promoting and risk-reducing behaviors (e.g., training in moderation skills). Prevention programs based on harm reduction principles are geared toward effective self-management.

In terms of treatment goals, harm reduction first attempts to stabilize the client's problem behavior and prevent further exacerbation of harmful consequences. In this respect, harm reduction is similar in purpose to tertiary prevention or relapse prevention: to enhance maintenance of behavior change and to keep the problem from getting worse. Once the target behavior is stabilized, the second goal of harm reduction is to encourage or facilitate reduction of harmful consequences, ranging from small decrements in risk to total cessation of the problem behavior.

Most familiar treatment approaches for addictive behaviors can be adopted within a harm reduction framework. Harm reduction interventions can be applied in the context of individual and group therapy, including self-help groups.

Pharmacotherapies may also be useful in harm reduction programs, such as the use of naltrexone to reduce alcohol craving, prescriptions of oral methadone for injection heroin users, or the application of nicotine replacements (such as nicotine patches) to aid smokers who wish to cut down or quit. Cognitive and behavior therapies are particularly well matched with a harm reduction approach, since they focus on behavior change based on the principles of learning and a continuum model of habit modification and coping skills training.

The Environment

The goal of reduced harm cannot be met unless the environmental means are available. In many cases, public policy dictates what can and cannot be legally done in making harm reduction tools and techniques more available. For now, it is sufficient to note that environmental access to harm reduction methods is intrinsically linked to matters of public policy.

Taking alcohol consumption as an example, policy dictates rules and regulations, such as establishing a legal drinking age, setting limits on blood-alcohol levels for drivers, limiting outlets or hours of sale for alcoholic beverages, and so on. Harm reduction, although it does not condone underage drinking or consumption to the point of intoxication, poses a pragmatic question: If it happens, what can be done to reduce the harmful consequences?

In Westhampton Beach, N.Y., the local taxi service has added 14 vans to their fleet to offer a service to those twenty-somethings who plan to go bar-hopping. Since that time the number of drunken driving arrests and late-night accidents has fallen sharply. This van service is but one example of an environmental measure to reduce harm among heavy drinkers.

Turning to injection drug use, environmental availability of harm reducing tools and settings represents a similar challenge. The availability of clean needles is associated with reduced risk of HIV infection. Having access to clean and safe places to inject drugs (e.g., Frankfurt's safe "shooting galleries") is associated with reduced risk of drug overdose deaths.

Public Policy

Public policies impact the environmental availability of harm-reducing agents such as the provision of clean needles to IV drug users or distribution of condoms to sexually active young people. Throughout this article, various public policy alternatives are described that would facilitate the reduction of harm for both substance use and its consequences. The most controversial policy topic, however, involves changing laws that regulate the consumption of illicit substances and provide penalties for those who break the law. Policies that exist in other countries, such as the distinction between hard and soft drug use and the decriminalization of cannabis use (Netherlands), or the ability of physicians to prescribe drugs to addicts (U.K., Switzerland), are currently rejected in the U.S.

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HARM REDUCTION: POLICY AND PRACTICE

By Diane Riley, Ph.D. and Pat O'Hare, Ph.D.

The Nature and Origins of Harm Reduction

Harm reduction is a relatively new social policy with respect to drugs that has gained popularity in recent years, especially in Australia, Britain, and the Netherlands, as a response to the spread of AIDS among injection drug users. Although harm reduction can be used as a framework for all drugs, including alcohol, it has primarily been applied to injection drug use (IDU) because of the pressing nature of the harm associated with this activity.

Harm reduction has as its first priority a decrease in the negative consequences of drug use. This approach can be contrasted with abstentionism, the dominant policy in North America, which emphasizes a decrease in the prevalence of drug use. According to a harm reduction approach, a strategy that is aimed exclusively at decreasing the prevalence of drug use may only serve to increase various drug-related harms. Harm reduction tries to reduce problems associated with drug use and recognizes that abstinence may be neither a realistic nor a desirable goal for some, especially in the short term. This is not to say that harm reduction and abstinence are mutually exclusive, but only that abstinence is not the only acceptable or important goal. Harm reduction involves setting up a hierarchy of goals, with the more immediate and realistic ones to be achieved in steps on the way to risk-free use or, if appropriate, abstinence; it is consequently an approach that is characterized by pragmatism.

Harm reduction has received impetus over the past decade because of the spread of AIDS: Drug use is one of the risk behaviors most frequently associated with HIV. In some areas, injection drug use has become the main route of drug administration, and globally it is now one of the primary risk factors for HIV infection. In some areas of the world, injection of drugs accounts for more than 80% of AIDS cases. What is more significant still is the rate at which HIV can spread amongst injection drug users. In cities such as Barcelona, Edinburgh, Milan and New York, between 50% and 60% of drug users have become infected. In Thailand, where less than 1% of users were infected in January of 1988, more than 40% were positive by September of that year, with a monthly incidence rate of 4%. In Canada, prevalence rates among injection drug users have reached 35% in Vancouver and 20% in parts of Montreal; incidence rates in several Canadian cities are above 10%, some of the highest levels in the developed world.

In all countries, HIV infection is not just a concern for the drug users themselves but also for their sexual partners. Worldwide, between 60% to more than 90% of heterosexually acquired HIV is related to IDU; at least 40% of IDUs are in relationships with non-users. Because of sexual spread from injection drug-using partners and because approximately one-third of IDUs are female, vertical spread to newborn children occurs.

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The possibility of transmission to the non-injecting community is increased by the fact that prostitution is sometimes used as a means of obtaining money for drugs and many prostitutes are regular or occasional injectors. In addition, IDUs are a potential source of perinatal transmission: Most pediatric AIDS cases in the United States are associated with injection drug use by one or both parents.

AIDS has thus been a catalyst for the rise in popularity of harm reduction, but in North America in particular harm reduction attracted attention because of effects of drug prohibition other than the spread of AIDS alone. The violent crime, gang warfare, prison over-crowding, and police corruption associated with prohibition have reached a level such that policy makers, practitioners, and members of the public alike are seeking alternatives to prohibitionist drug policy. It has been claimed that attempts to legislate and enforce abstinence are counterproductive and that there are harms due to these measures that are far worse than the effects of the drugs themselves. The harm reduction approach attempts to identify, measure, and minimize the adverse consequences of drug use at a number of levels: individual, community (family, friends, colleagues, etc.), and societal.

> *Harm reduction can be used as a framework for all drugs, including alcohol.*

The roots of harm reduction as we now know it are in the United Kingdom, the Netherlands, and North America. In the 1980s, three important factors led to the establishment of the Merseyside model of harm reduction in the U.K.:

a.) The ability of physicians to prescribe drugs, including heroin;

b.) The early establishment of syringe exchanges; and

c.) The cooperation of the local police.

All the available evidence on HIV infection among IDUs in Merseyside suggests that the Merseyside HIV prevention strategy for IDUs is very effective, with extremely low levels of HIV in drug users and a decrease in drug-related acquisitive crime in many parts of the region, while the national rate is increasing.

In the early 1980s, Amsterdam recognized that drug use is a complex, recurring behavior and that reduction of harm means providing medical and social care in order to avoid some of the more harmful consequences of injection drug use. Needle exchange began in 1984, and since then many Dutch cities have taken a pragmatic and non-moralistic attitude toward drugs that has resulted in a multifaceted system that offers a variety of harm reduction programs. Police in the Netherlands focus their attention and resources on drug traffickers, not on users.

Methadone maintenance programs for opiate users began in Canada in the late 1950s and in the United States in the early 1960s. The spread of AIDS in opiate users has led to expansion and liberalizing of methadone programs in a number of countries with good results, but many other countries, including Canada and the United States, are slow to provide an adequate response to the AIDS crisis.

A number of countries or regions have adopted harm reduction as both policy and practice. For example, the British Advisory Council on the Misuse of Drugs has stated: "We have no hesitation in concluding that the spread of HIV is a greater danger to individual and public health than drug misuse. Accordingly, services which aim to minimize HIV risk behavior by all available means should take precedence in developmental plans." The World Health Organization has expressed a similar opinion, stating that policies aimed at reduction of drug use must not be allowed to compromise measures against the spread of AIDS.

Features of Harm Reduction

The main characteristics or principles of harm reduction are:

Pragmatism: Harm reduction accepts that some use of mind-altering substances is inevitable and that some level of drug use is normal in a society.

Humanistic Values: The drug user's decision to use drugs is accepted as fact, as his or her choice; no "moralistic" judgment is made either to condemn or to support use of drugs, regardless of level of use or mode of intake. The dignity and rights of the drug user are respected.

Focus on Harms: The extent of a person's drug use is of secondary importance to the harms resulting from use.

Balancing Costs and Benefits: Some pragmatic process of identifying, measuring, and assessing the relative importance of drug-related problems, their associated harms, and the costs/benefits of intervention is carried out in order to focus resources on priority issues. The framework of analysis extends beyond the immediate interests of users to include broader community and societal interests.

Hierarchy of Goals: Most harm reduction programs have a hierarchy of goals, with the immediate focus on addressing the most pressing needs.

Definition

At present there is no agreement in the addictions literature or among practitioners as to the definition of harm reduction. Harm reduction can be viewed as both a goal and a strategy. A more narrow definition of harm reduction as a strategy rather than as a goal removes some of the confusion. As a specific strategy, the term harm reduction generally refers to only those policies and programs that aim at reducing drug-related harm *without requiring abstention from drug use.* Thus defined, harm reduction strategies would *not* include strategies such as abstinence-oriented treatment programs or the criminalization of illicit drug use. So while drug policies and programs may be aimed at reducing drug-related harm, not all policies and programs with a goal of harm reduction are harm reduction strategies. A harm reduction approach to a person's drug use in the short term does not rule out abstinence in the longer term. Indeed, harm reduction approaches are often the first step towards the eventual cessation of drug use.

Harm Reduction Programs and Policies

1. Syringe Exchange and Availability

Needle and syringe exchange programs were first established in a few European countries in the mid-1980s and, by the end of the decade, were operating in numerous cities around the world. The rationale behind syringe exchanges is that many people who are currently injecting are unable or unwilling to stop, and intervention strategies must help reduce their risk of HIV infection and transmission to others. Provision of sterile needles and syringes is a simple, inexpensive way to reduce the risk of spreading HIV infection. It is also a way of providing contact with drug users through outreach services.

2. Methadone Programs
Methadone is a synthetic substitute for opiates that is much longer lasting in its effects, thereby reducing the need for the user to resort to street drugs. Numerous studies have been done on the effectiveness of methadone, and the vast majority of these have shown that it reduces deaths, reduces the users' involvement in crime, curbs the spread of HIV and hepatitis, and helps drug users to gain control of their lives.

3. Prescribing of Drugs Other Than Methadone
In a tradition dating back to the 1920s, physicians in the United Kingdom prescribe drugs to users. The majority of clients receive oral methadone, but some receive injectable methadone, others receive injectable heroin, and a small number receive amphetamines, cocaine or other drugs. Based on the success of the British model in reducing drug-related harms, Switzerland has carried out a national experiment of prescribing heroin to users over a three-year period. Results of the experiment show that a heroin maintenance program can be efficacious in that the health and well-being of the users in the programs clearly improved. The authorities concluded that heroin causes very few, if any, problems when it is used in a controlled manner and is administered in hygienic conditions. Holland began a heroin maintenance experiment in 1998, and several German cities plan to begin programs. The feasibility of carrying out an experimental program of heroin prescription in North American cities is currently underway.

> *Harm reduction has as its first priority a decrease in the negative consequences of drug use.*

4. Education and Outreach Programs
Educational materials about drugs that have a harm reduction focus are readily available in a number of countries including the United Kingdom, Holland and Australia, but they remain extremely controversial and often unavailable in most others. While not promoting drug use, such materials tell the user how to reduce the risks associated with using drugs, teaching such things as safer injecting practices.

5. Law Enforcement Policies
Merseyside Police in the northwest of England have devised a harm reduction approach known as "Responsible Demand Enforcement." Merseyside Police developed a cooperative harm reduction strategy with the Regional Health Authority to improve the prevention and treatment of drug problems, particularly with respect to the spread of HIV infection among injection drug users. The police are represented on Health Authority Drug Advisory Committees and employ Health Authority officers on police training courses involving the drugs/HIV issue. They have also supported the Health Authority by agreeing not to conduct surveillance on them, referring arrested drug offenders to services, not prosecuting for possession of syringes that are to be exchanged, and publicly supporting syringe exchange. One of the most important features of the Merseyside Police strategy has been its emphasis on using resources to deal with drug traffickers while operating a cautioning policy toward drug users. "Cautioning," which has now been adopted to some extent by all police authorities in Great Britain, has been recommended by the Attorney General of the U.K. as an appropriate option for some classes of offense such as drug possession. The overall effect of this policy is to steer users away from crime and possible imprisonment. In recent years the approach has been extended to ecstasy, amphetamine, and cocaine as well as heroin. In the Netherlands, police have long been supportive of harm reduction programs, including *de facto* decriminalization of marijuana and creation of tolerance zones; enforcement efforts are concentrated on large-scale traffickers and on ensuring a safe and peaceful environment. Some police stations in Amsterdam will provide clean syringes on an exchange basis. In Hamburg, Germany, a recent policy shift to harm reduction has been reflected in co-operation between police, health officials, and drug user groups working together to help drug users access social services.

6. "Tolerance Areas"
One innovative harm reduction approach being practiced in several European cities involves toleration by authorities of facilities known as "injection rooms," "health rooms," "contact centers," or similar terms. These are facilities where drug users can get together and obtain clean injection equipment, condoms, advice, medical attention, and so forth. The majority of these places allow users to remain anonymous. Some include space where drug users, including injectors, can take drugs in a comparatively safe environment. This is regarded as better than the open injection of illicit drugs in public places or consumption of drugs in "shooting galleries" that are usually unhygienic and controlled by drug dealers.

7. Alcohol Programs
Moderate drinking programs: One means of reducing the harms associated with alcohol is to teach people to consume alcohol in a moderate or sensible manner.

Standard drink labels: "Standard serving" information involves stating the amount of ethyl alcohol in the container in relation to the amount of alcohol in a normal or "standard" serving.

Server intervention programs: One way to reduce the harms associated with immoderate alcohol consumption is to train servers to recognize and intervene to limit impairment in their patrons.

8. Nicotine Policies and Programs
Harm reduction approaches to nicotine products focus on reducing the harms to the user as well as to the inhaler of second-hand smoke. They include a wide range of approaches from policies controlling smoking in public places to delivery of nicotine through gum, patches, inhalers, and smokeless cigarettes.

9. Marijuana Policies
Several countries or parts thereof, including the Netherlands, South Australia, and Germany, have introduced *de facto* decriminalization of small amounts of cannabis as a harm reduction strategy. In each of the cases where marijuana law reform has occurred, the final decision was based on the fact that the costs associated with the existing system were seen to be too high by many segments of society and too many people were seen as being adversely

PRINCIPLES OF HARM REDUCTION

Harm Reduction is a set of practical strategies with the goal of meeting drug users "where they're at" to help them reduce any harm associated with their drug use. Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of, or formula for, implementing harm reduction. However, the Harm Reduction Coalition considers the following principles central to harm reduction practice:

- Harm Reduction accepts, for better and for worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Harm Reduction ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them, and both affirms and seeks to strengthen the capacity of people who use drugs to reduce the harm associated with their drug use.
- Harm Reduction understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Harm Reduction establishes quality of individual and community life and well-being—not necessarily cessation of all drug use—as the criteria for successful interventions and policies.
- Harm Reduction calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Harm Reduction recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to, and capacity for, effectively dealing with drug-related harm.
- Harm Reduction does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

Compliments of the Harm Reduction Coalition (http://www.harmreduction.org). Used with permission.

affected by the existing laws. In all of the cases where *de facto* decriminalization of marijuana has occurred, reduced financial and social costs were achieved without an increase in the risks to the community associated with drug use in general. Other longer-term benefits have stemmed from the separation of high- and low-risk drug markets.

Conclusion

The popularity of harm reduction on an international scale is evidenced by the increasing support for the International Conference on the Reduction of Drug-Related Harm, now in its tenth year, and by the formation of the International Harm Reduction Association (IHRA).

Despite the increase in popularity amongst workers in the field, many health and addictions agencies in North America and elsewhere remain ambivalent about harm reduction as it pertains to alcohol and other drugs. Harm reduction raises some difficult questions, but it is evident that it is better to debate these openly rather than to ignore them as has been done all too often in the past. Comprehensive harm reduction programs that are culturally sensitive are necessary: Harm reduction must be multifaceted, not just a singular intervention. The data regarding such drug-related consequences as AIDS make it clear that we need a long-term plan for harm reduction. Risk reduction is a social process, it is not something that public health officials can impose; an effective program must provide multiple means for behavior change and needs to be conducted on a long-term basis.

> *Most harm reduction programs have a hierarchy of goals, with the immediate focus on addressing the most pressing needs.*

Harm reduction, in the final analysis, is concerned with ensuring the quality and integrity of human life, in all its wonderful, awful complexity. Harm reduction does not portray issues as polarities, but sees them as they really are, somewhere in between; it is an approach that takes into account the continuum of drug use and the diversity of drugs as well as of human needs. As such, there are no clear-cut answers or quick solutions. Harm reduction, then, is based on pragmatism, tolerance and diversity: In short, it is both a product and a measure of our humanity.

For a more detailed discussion of these issues see:

Riley, D.M. (1993). *The Policy and Practice of Harm Reduction.* Ottawa, CCSA;

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Want to discuss Harm Reduction with your colleagues?
Visit the discussion board on our Web site: http://www.TPRonline.org

UPCOMING TOPICS

INHALANTS

The 1999 Monitoring the Future survey shows that one in five (19.7%) eighth graders have used inhalants in their lifetime, and one in ten (10.3%) have used in the past 30 days. Unlike other drugs, which peak in use in late adolescence, inhalant use is most prevalent among younger students. This early use is due, in part, to the availability and low cost of inhalants. Volume 7(3) of *The Prevention Researcher,* to be mailed the first of September 2000, will focus on this important and potentially deadly topic.

SELF-INJURY

Also called self-mutilation and self-inflicted violence, self-injury is the intentional harming of one's own body without suicidal intent. Cutting is the most common form of self-injury but burning or hitting oneself are also methods. Dr. Armando Favazza, the most prominent researcher in self-injury, estimates the number of sufferers at 750 per 100,000 Americans. Self-injury typically begins in adolescence. Volume 7(4) of *The Prevention Researcher* will delve into this little known or understood behavior.

GAY, LESBIAN AND BISEXUAL YOUTH

Exact estimates of the number of high school youth who self-identify as gay, lesbian or bisexual are hard to determine. One self-report questionnaire distributed at a Northern California school found 6% of the students to self-identify as gay, lesbian, or bisexual, and another 13% to be unsure. Additionally, it has been estimated that 9 students in 30 are directly affected by these issues; either they have a gay or lesbian parent, sibling or relative, or they are gay themselves. Gay, lesbian and bisexual students have shown to have higher rates of suicide and substance abuse and are disproportionately represented in the street youth population. Volume 8(1) of *The Prevention Researcher* will look at the special, and mostly unmet, needs of this largely invisible population.

OTHER FUTURE TOPICS INCLUDE

- Adolescent Tobacco Use
- Street Youth
- Teenage Depression

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USING THE HARM REDUCTION MODEL WITH NEW YORK CITY STREET YOUTH

By Michael C. Clatts, Edith Springer, W. Rees Davis, Glenn Backes, Christopher Linwood, Marie Bresnahan, and Stacey Rubin

Studies indicate that as many as two million adolescents in the United States are homeless, and that as many as 200,000 youth live as permanent residents of the streets. Degraded by the effects of street prostitution and the loss of their child hood, and overwhelmed by feelings of self-doubt and self-blame, many turn to the ephemeral comfort afforded by street drugs. Quickly lost in a downward spiral of self-destruction, these youth become increasingly dependent upon the vicissitudes of the street economy—a system of exchange in which they are easily exploited and over which they have very limited power. Of particular concern in terms of risk for health are the high frequencies of both sexual and drug-related risk behaviors that place these youth at high risk for HIV infection.

This article aims to describe the way in which the harm reduction model has been applied to the development of comprehensive HIV outreach and prevention services targeted to street youth in New York City.

History of HIV Prevention Services for Street Youth in New York City

The development of prevention services targeted specifically at street youth began in the mid-1980s with a small number of community-based street outreach programs. Originally outreach programs were envisioned as a way to prevent youth from becoming involved in the street economy by using street outreach as a means of bridging youth with the mainstream social-services system, including services that could return them home.

However, outreach workers found many of these youth did not have families to which they could return, or were from family environments that were themselves hazardous. Many youth came to the streets having already been exposed to profound emotional trauma, experiences that were exacerbated by the violence and exploitation that characterize the everyday life of street youth. Mainstream adolescent services were often ill-equipped to meet the complex social, economic, and emotional needs of these youth, a fact that has only served to further alienate this population.

In response to the unmet service needs of this population, many of the programs began to develop a wider range of services that included local drop-in centers where more intensive services tailored to the specific needs of these youth could be offered. Early in the AIDS epidemic, all or most of these services included specific attention to HIV education and prevention.

Applications

In recent years, as increasing numbers of street youth have become ill with opportunistic infections associated with HIV, prevention has taken on an increased prominence in service delivery and heightened attention to the need for a systematic approach. These developments prompted a new look at service-delivery models as well as at some of the intervention theories that have been applied to HIV prevention among other groups at high risk for HIV infection. For example, a number of the projects experimented with the use of service-delivery models based upon abstinence-based models. Following these models, project staff stressed abstinence as the only healthy and safe choice, an initiative that proved to be a wholesale failure among youth.

Generally speaking, outreach workers had been successful in learning how to engage street youth—in great part because of the principle of unconditional acceptance of each young person as an individual that each project embraced. Staff acknowledged that youth lived in dangerous conditions and that prostitution and criminal activity were part of surviving. Around issues of drug use, however, project services were sometimes denied to youth because of their continued drug use. The clear message was that drug use was wrong and that use endangered access to services. Implicitly, emphasis on an abstinence model also communicated that youth who failed to measure up to this standard were in some way wrong, deficient, and perhaps unworthy of services. In response, many drug-using youth became alienated from services, while others were inclined to misrepresent their drug use, negating any possibility of therapeutic discussion (including a critical opportunity for HIV intervention).

It is important to understand that in many respects these youth have rejected mainstream services and approaches to service delivery, particularly services such as medical care and drug treatment that are typically delivered in a highly structured institutional environment and often in a highly coercive manner. Many are survivors of rape, incest, sexual abuse, and other forms of physical and emotional abuse, largely at the hands of adults. Many of these youth survive through street prostitution—yet another experience of uncaring, exploitative adults. There should be little wonder that they are wary of authority figures and distrustful of the behavioral messages that these systems articulate.

Over and above the fact that this approach did not serve the youth, it should be emphasized that it also took an enormous toll on service providers. Many outreach workers felt they were in a near-constant state of conflict with youth, and they were expected to use the opportunity of outreach as an occasion in which to impose a set of behavioral goals that were not accomplishable given the limited choices that many street youth have.

In 1992, several of the outreach projects agreed to participate in a multi-city, Centers for Disease Control (CDC)-funded, evaluation of the efficacy of street outreach services in relation to HIV risk reduction. Participation in this study occasioned a re-examination of the service-delivery principles upon which services had been developed, and the harm reduction model was used as a theoretical foundation for this evaluation. A network of outreach programs—the Youth At Risk Cooperative—was developed. One of the primary functions of the YAR Cooperative was the development of an interagency training program for street outreach workers who serve homeless youth. Historically, outreach workers received little if any formal training, typically no more than an orientation to the agency itself rather than training in street outreach *per se.* Thus, outreach workers were often left to develop outreach skills principally by means of trial and error. Together with their own personal skills, this led to some very innovative outreach approaches in the development of effective service relationships with a population that is both "hard-to-reach" and "hard-to-maintain." However, the lack of any formal training made for inconsistency in the kinds of information and skills with which outreach workers were equipped, and in the kinds of messages that they provided. It also resulted in considerable staff burn-out and frequent staff turnover. Particularly in the context of a population in which the development of long-term service relationships is very important, this can limit the impact that outreach has in fostering sustained risk reduction.

> *The principal public-health goal is one of providing risk-reduction choices rather than of seeking to impose a uniform code of behavior.*

The harm reduction model was used as the foundation for the training program for outreach workers and included skill-building exercises using the harm reduction model specifically within the street milieu. Most (93.8%) outreach workers found the training "very relevant" to their work with street youth, and most felt they would use what they learned "extensively" in their work with street youth. Perhaps more persuasive in terms of the potential of the harm reduction model as a service-delivery strategy for this population, however, are some of the case studies that were developed by staff who have integrated the model into their case-management activities.

Frankie

Frankie had participated in the Times Square street economy for several years, and was homeless when he was first encountered by outreach workers. One evening he approached outreach workers and apologized for the fact that he was "high," but requested the opportunity to talk to someone. The outreach worker took him aside, indicating that he would be happy to talk with him. Frankie further explained that if it were not for the fact that he had taken some dope, he would never have had the courage to come talk to the outreach worker. The outreach worker acknowledged that it is sometimes difficult to know whom to trust on the streets, and that some kinds of things were hard to talk about even with someone who could be trusted. The outreach worker also indicated that he felt it was good that Frankie had figured out a way to move beyond his fear, saying, "Good, I'm glad you had a little dope then. What's up, what's bothering you?"

Frankie explained that he had tested HIV-positive six weeks before, and he had been "binging" on heroin and "going crazy" until the previous day, when he decided to do only six bags instead of twelve, and to try to talk to someone. At this point Frankie said, "Sorry, I know I'm still messing up and I want to quit using."

Such situations always pose a quandary in working with street youth. Is the youth ready and able to abstain from drug use? Or is he saying that he wants to abstain because he is afraid if he doesn't promise abstinence he will be denied services? In response, the outreach worker said, "I'll help you with that if you want. If you want, we could work on finding you a place to stay, and on your medical stuff first. Whatever you want to do." They went on to discuss whether there would be ways for Frankie to reduce his use of heroin to the extent necessary to attend important appointments related to obtaining housing. The outreach worker also explained ways in which Frankie could reduce his risk for complications associated with drug injection through proper needle-hygiene practices.

This first conversation lasted an hour, and was used by the counselor to build trust and to share limited suggestions, such as "How about doing a bag in the morning, then coming to see me? Or how about doing something else related to getting off the streets, and getting high only at night after these things have been taken care of?" The client thought these suggestions were possible. It was hoped that if Frankie successfully changed his behavior to control the time and dose of the drug, he would feel that he had some power over the drug, instead of the drug holding absolute power over him. Frankie began coming to the project the very next day, reflecting an engagement in the service delivery that would probably never have occurred if the strategy employed by the outreach worker was not grounded in the recognition that prevention services must begin with the actual needs and capacities of the individual to whom they are directed.

Lee and Al

Another example involves two youth—Lee and Al—who were encountered on a street corner in Manhattan. Noting the puddle of vomit by their feet, the outreach workers surmised that the two were stoned on heroin. One outreach worker inquired, "How's the dope?" Al replied, "What? I ain't high." The counselor put his hand on Al's shoulder and asked, "Who the hell stands around a pile of puke, and looks so happy about it?" Al looked down at the vomit, and then laughed. The outreach worker warned them not to step in it, and for Lee to remember his appointment at the project the next day.

Angel

An outreach worker observed that Angel used crack in a binge pattern of several days and nights getting high and prostituting, followed by several days of sleep and physical recovery. The outreach worker asked Angel what she did when she wanted to end a binge. She replied, "Two dime bags, and a Valium," which she usually bought on her fourth day into a binge. The marijuana, she said, stimulated her appetite enough to eat, and the combined effect of the depressant drugs and food allowed her to sleep for a couple of days, after which she could usually abstain from the drug for three days to a week.

"Binging" typifies the way in which many street youth use drugs, particularly stimulant drugs such as crack cocaine. This pattern of cocaine and crack cocaine use is one in which a youth abstains from drugs for as long as is tolerable, and then is driven to consume large amounts of the drug over a period of days, or even weeks, foregoing needed sleep, food, and shelter. In both emotional and behavioral terms, periods of binging are often the most risky periods in the daily life of street youth, often marked by profound depression and feelings of self-destruction. Binging is characterized by extremely high levels of drug consumption, often using street prostitution as a means to obtain the money. Outreach workers find that they can sometime identify warning signs that prefigure binges. Dialogue between a youth and an outreach worker can sometimes assist in the formulation of plans to interrupt this cycle, or at least to mitigate its harmful effects. As in the previous case study, however, the opportunity for such a dialogue is contingent upon the outreach worker being able to communicate acceptance, concern, and knowledge, and a willingness to provide an intervention environment in which a youth is assisted in directing his or her own self-care plan. In talking with Angel, the outreach worker suggested that before she smoked any more crack, she could invest in marijuana and Valium, to be taken after the second full day of getting high. Angel was successful with this plan, using this technique to shorten a binge and sometimes even to avoid one.

> *It is critical that we remember to fit the service model to the youth, rather than the youth to the service model.*

Discussion

It is beyond the scope of this article to demonstrate in any formal sense that the harm reduction model has broad and sustained behavioral efficacy. Based upon the experience of service providers participating in the study, however, two salient features of the harm reduction model can be identified: First, as an approach to public-health policy, the harm reduction model is clearly predicated upon the recognition that some "behavioral outcomes" have greater importance than others. Specifically, the harm reduction model prioritizes the prevention of HIV transmission. Second, as a strategy by which to achieve reduction in the transmission of HIV, the harm reduction model is based on the recognition that particular behavioral goals must be tailored to the specific needs and real-life capacities of the individuals to whom they are directed. In the context of outreach to a population such as street youth, the principal public-health goal is one of providing risk-reduction *choices* rather than of seeking to impose a uniform code of behavior or using access to service-related resources as a condition for access to care. Here, the harm reduction model serves a service-delivery principle in which the task is that of providing risk reduction education and tools that will enable an individual to make the most health-promoting choices possible in a particular place and time. As such, it contrasts rather sharply with approaches to service delivery that are predicated upon idioms of failure, blame, and deviance. It also contrasts with "incentive" strategies for behavioral change that rely on the mediums of coercion, penalty, and criminalization. Thus, the harm reduction model contrasts with many of the more "mainstream" behavior change models whose behavioral goals are derived from outside the particular social and economic contexts in which the youth lives.

In the context of the case studies discussed above, for example, it was more important that the outreach worker establish an effective relationship with Frankie than it was to tell Frankie that he should not use drugs. The health and well-being of the individual person, and the direct response to the needs that he or she defines as primary, are first-order goals of service delivery, not an abstract set of agency standards and procedures that have been cut and pasted across all service interactions. In sharp contrast to rationalist models of service delivery, it is our experience that the harm reduction approach is much more likely to result in the development of the kind of relationship in which specific and realizable behavioral goals can be identified. Moreover, it is also the kind of service-delivery relationship upon which risk-reduction changes in behavior can be supported, and thereby sustained. For example, it was more important to teach Angel how to minimize the potential harm of HIV infection from binging during prostitution than it was to direct her to stop using drugs and stop prostituting— goals that at that point in time were not realizable given the social and economic options available.

Conclusion

Service providers employing the harm reduction model have resonated with the "non-judgmental" posture it encompasses and with the attention to "real life" behavioral choices that the model embraces when applied to a given clinical context. In attempting to develop HIV prevention services for street youth, it is critical that we remember to fit the service model to the youth, rather than the youth to the service model. The use of the harm reduction model has contributed to this process in several concrete ways that have been described here in the context of an outreach-worker training program. More generally, but no less substantively, the harm reduction model has also served to remind us that we cannot offer constructive assistance until we know that person to whom we are reaching out, and that we cannot know that person until we are prepared to listen.

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RESOURCES

The Dogwood Center
http://www.dogwoodcenter.org/

The Dogwood Center "is an independent, nonprofit research organization concerned with social justice issues involving drugs and AIDS." Most of the articles at this site were written by the Center's founder, Dawn Day.

DrugText
http://www.drugtext.org/

DrugText is "the Internet's center for substance use-related risk reduction." This site, which is available in a variety of languages, contains numerous international on-line articles, books, and reports. Many of the on-line articles are reprinted from real-life journals. Unfortunately, it is often difficult to discern what year they were written. This site is not well organized but does include a search engine. There is a wealth of information here for people willing to take the time to scroll through the lists of titles.

Harm Reduction Coalition
http://www.harmreduction.org/

This Web site is offered in both English and Spanish. The Harm Reduction Coalition offers information on the principles of harm reduction, its programs and functions (including community organizing), and a list of upcoming conferences.

JAMA HIV/AIDS Information Center
http://www.ama-assn.org/special/hiv/

The JAMA (Journal of the American Medical Association) HIV/AIDS Information Center includes several documents on the effectiveness of needle exchange programs and condoms in reducing the spread of AIDS.

The Lindesmith Center
http://www.lindesmith.org/

The Lindesmith Center "is a policy research institute founded in 1994 that focuses on broadening the debate on drug policy and related issues." Its guiding principle is harm reduction and its on-line library is full of documents on this topic. This library includes documents produced by the Lindesmith Center and links to documents by other organizations and journals, such as a link to "Primary Care as Harm Reduction for Injection Drug Users," which appears on the JAMA (Journal of the American Medical Association) Web site. A sampling of other documents in the library includes: "Safety First: A Reality-Based Approach to Teens, Drugs, and Drug Education"; "Kids, Drugs, and Drug Education: A Harm Reduction Approach"; "Harm Reduction: A Public Health Strategy"; and "Injection Drug Users: Tips on Management (What About Prevention?)."

North American Syringe Exchange Network
http://www.nasen.org

The North American Syringe Exchange Network is "dedicated to the creation, expansion, and continued existence of syringe exchange programs as a proven method of stopping the transmission of blood borne pathogens in the injecting drug using community." This Web site includes links to Needle Exchange Program Web sites, reports and literature on syringe exchange, and links to safe sex resources and HIV/AIDS information.

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The PREVENTION RESEARCHER

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INHALANT ABUSE: THE SILENT EPIDEMIC

By Harry Fullwood, Ph.D. and Dean W. Ginther, Ph.D.

When modern technology formulated the volatile chemicals that are essential agents in such useful products as paints, glues, and household cleansers, no one anticipated that these substances, together with petroleum products such as gasoline and kerosene, would be the source of a major problem among adolescents —inhalant abuse.

Perhaps the most widespread and least publicized form of drug abuse, inhalant abuse is only now beginning to gain the attention and concern of middle school administrators, who are becoming increasingly aware of its extent and the damage it can cause.

What Is Inhalant Abuse?

The National Institute on Drug Abuse (NIDA) defines inhalants as breathable chemical vapors that produce mind-altering effects. The street term "huffing" refers to inhaling a volatile vapor for mood-altering purposes, usually with the assistance of a cloth or some type of paraphernalia. Most substances used as inhalants belong to a large group of compounds classified as volatile solvents.

> *The most recent Monitoring the Future study shows that 19.7% of eighth graders admitted to any lifetime inhalant use.*

Generally, the intoxicating vapors are inhaled through the nose or mouth, although toxic agents are sometimes ingested or absorbed through the skin. Common practices include:

- Inhaling directly from containers
- Inhaling with plastic or paper bags placed over head
- Inhaling from saturated cloth
- Inhaling from other containers such as pop cans or balloons
- Inhaling from aerosols sprayed into nose or mouth
- Inhaling vapors emitted by heating a volatile substance

What Do They Inhale?

Adolescent abusers usually choose inhalants based on availability, the desired physiological effect, and the degree of social and legal risk associated with possessing the substance. While many household and commercial products can be used as inhalants, those most widely abused include gasoline, paints, certain glues, and aerosols, most of which may be easily obtained or purchased. The following list, published by the Texas Commission on Alcohol and Drug Abuse, includes some of the most commonly abused substances.

Adhesives: model airplane glue, rubber cement, PVC cement, false eyelash and fingernail adhesives, and household cements.

Aerosols: paint sprays, hair sprays, deodorants, air fresheners, and asthma sprays.

Anesthetics: nitrous oxide, halothane, and ethyl chloride (local).

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FROM THE EDITOR'S PC

Dear Colleagues:

We welcome you to our fall issue of *The Prevention Researcher* newsletter. This issue is devoted to the understanding of inhalant use and the prevention of this toxic form of substance abuse by many of our youth. We feel that this issue presents a solid background and understanding of the concerns that all of us have around the prolific use of inhalants among teens.

Our guest contributors for this issue are Dr. Harry Fullwood of the Department of Psychology and Special Education at Texas A&M University, Dr. Fred Beauvais of the Tri-Ethnic Center for Prevention Research at Colorado State University, Dr. Elaine Adams Thompson of the University of Washington School of Nursing in Seattle, and Dr. Pamela Jumper-Thurman of the Psychology Department at Colorado State University.

I would like to invite you to our Web site, which we are constantly updating to act as an enhanced feature of our print issues. We've recently included a comprehensive index, a search engine, and annotated links to all the Web sites we've reviewed over the past several years (more than 300 in all). Additionally, we are maintaining a discussion board and have added an announcement e-mail mailing list.

We hope you will visit our Web site and contribute your thoughts, comments, and input. We appreciate the feedback!

Steven Ungerleider, Ph.D.
Psychologist/Editor

Cleaning Agents: dry cleaning fluids, spot removers, and degreasers.

Solvents: polish removers, paint removers, paint thinners, correction fluids, butane fuel, lighter fluids, and fire extinguishing chemicals.

Food Products: whipped cream dispensers (nitrous oxide).

How Widespread Is It?

The most recent (1999) Monitoring the Future study (a national survey of high school twelfth, tenth and eighth graders) shows that 19.7% of eighth graders admitted to any lifetime inhalant use. In the same study, the annual prevalence use for eighth graders peaked at 12.8% in 1995 and has declined to 10.3% in 1999. Similarly for twelfth graders, annual prevalence peaked in 1995 at 8.0% and has since declined to 5.6% in 1999 (see Figure A). In 1999, one in ten (10.3%) eighth graders, one in fifteen (7.2%) tenth graders, and one in twenty (5.6%) twelfth graders had used inhalants in the past year. Of course, this survey does not include youth who have dropped out, or who have been expelled or suspended.

Among eighth graders, females consistently have a slightly higher annual prevalence rate.

Use by African-American students appears to be least prevalent. Combining data from the 1997 and 1998 Monitoring the Future surveys, 4.2% of African-American eighth graders had used inhalants in the past year, compared to 13.3% of white and 11.5% of Hispanic eighth graders.

Data from 1991 through 1998 shows that among eighth graders, females consistently have a slightly higher annual prevalence rate (11.6% in 1998 vs. 10.6% for males); however, this trend does not hold for the older grades with 7.6% of tenth grade females using inhalants compared to 8.4% of tenth grade males.

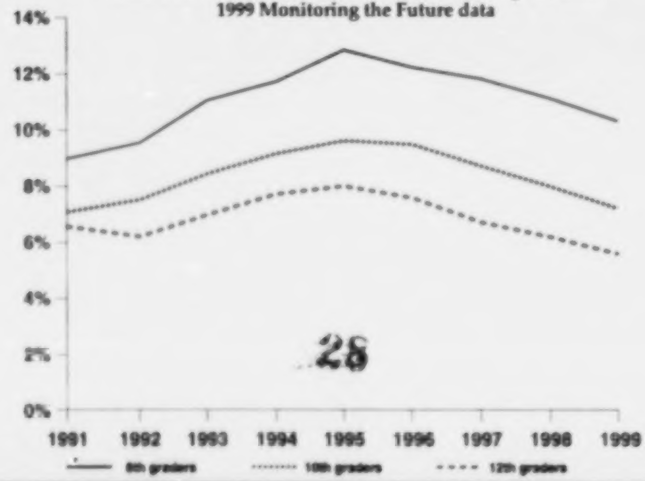
More severe sanctions for traditional forms of drug abuse, plus the low cost and easy availability of inhalants, make them attractive to some students. Another factor that makes inhalants appealing is that they can be used quickly, with little risk of detection. Unlike other drugs that require specific paraphernalia (such as hypodermic syringes), all one needs to "huff" is the substance of choice and something to contain the vapors. The equipment required is readily available in homes, garages, and even schools: plastic food storage bags, paper bags, glass or plastic bottles, containers of all types and sizes, aluminum cans, cloth, and tablespoons (for heated substances).

Unfortunately, it is difficult for principals and staff to determine whether a suspected student's empty sandwich bag or container is evidence of abuse. Thus, users enjoy a certain degree of safety from detection.

What Are Its Effects?

Many abusers believe that infrequent, experimental, or recreational use of

Figure A
Annual Prevalence of Inhalant Use by Grade
1999 Monitoring the Future data



volatile solvents is not dangerous. But while relatively few deaths occur as a direct result of inhalant poisoning, a number of people die each year from asphyxiation, suffocation, choking on vomit, careless behavior, and "sudden sniffing death syndrome"—all directly or indirectly related to huffing.

School personnel should be aware of certain behavioral signs or symptoms that may indicate habitual inhalant abuse. These include:

- Short-term memory loss
- Emotional instability
- Cognitive impairment
- Slurred speech
- Uncoordinated movements
- Mood swings
- Loss of smell and/or taste
- Loss of appetite
- Quickness to anger
- Passive-aggressive tendency
- Chemical smell in clothing, hair, or breath
- Possession of inhalant materials.

A number of organic solvents, such as toluene, may cause acute and irreversible brain damage at high levels of use. Although statistical evidence of physical or emotional abnormalities caused by long-term abuse of other inhalants is subject to controversy, the desired euphoria of "huffing" is often followed by headaches, dizziness, and a loss of coordination.

Lack of knowledge about inhalant abuse is common among school personnel and parents.

What Can We Do About It?

It is not clear if traditional drug treatment approaches are effective with inhalant abusers. Specific treatment and prevention strategies for inhalant abuse must be developed and tested before successful intervention can be achieved.

Unfortunately, lack of knowledge about inhalant abuse is common among school personnel and parents. Although personal tragedies resulting from inhalant abuse bring media attention and public demands to do something about the problem, the attention is often short-lived and has little effect on school policy or curriculum.

A reasonable approach that might be considered by principals of middle schools centers around information-sharing and communication. Public agencies and social service organizations can provide informative and youth-oriented materials—including videotapes, cartoon books, coloring books, brochures, and pamphlets—at little or no cost to public schools. These materials contain frank and specific information on the effects of inhalant abuse on learning, on its physical and emotional effects, and on intervention strategies.

Drs. Harry L. Fullwood and **Dean W. Ginther** are professors in the Psychology and Special Education Department at Texas A & M University, Commerce, Texas.

This article has been updated from: Harry L. Fullwood & Dean W. Ginther (1994). Inhalant Abuse: The Silent Epidemic. *Principal, 74* (Nov. 1994), pgs 52-53. Reprinted with permission.

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INHALANT ABUSE: CAUSES, CONSEQUENCES AND PREVENTION

By Fred Beauvais, Ph. D.

Recent studies have shown that about one-fifth of American adolescents have experimented with or used inhalants at some point in their lives and that this number has increased substantially over the past 20 years. While this is a significant number, only 5-10% of youth have used inhalants within the past year and 2-5% within the past month. These numbers indicate that most use is either one-time use or use for a brief period of time and that the majority of youth who use inhalants should not be considered chronic abusers. The focus of this article is on that group of people who go beyond experimentation or brief periods of use and for whom inhalants present serious problems.

Causes and Consequences of Inhalant Abuse

The question of what is a cause and what is an effect is a major problem when looking at substance use behavior. For example, inhalant users are known to have poor academic performance. Does this poor performance lead to frustration, problems in school and then the use of inhalants? Or, does inhalant use interfere with cognitive functioning and thus lead to poor school performance? While the search for "cause and effect" relationships may be useful at some point, it may be more helpful to consider the characteristics of inhalant users as interactive. For example, a child from a family with many problems may be prone to inhalant use, but it also is likely that the use of inhalants only increases that family dysfunction.

When compared with either non-users or with users of other drugs, inhalant abusers tend to have greater difficulty in school.

Resolution of the problem involves addressing both the family issues and the inhalant use.

Characteristics of Inhalant Abusers

A wide range of problems has been implicated in the development of inhalant abuse. Many of these are common to those who abuse other drugs or are otherwise socially deviant. What marks inhalant abusers is that they appear to exhibit more of these problems and often to a greater degree than other drug users. What follows may seem to be an extreme depiction of individuals who abuse inhalants. It must be kept in mind that all individuals who abuse inhalants do not share all of the characteristics described and that there is a range of "seriousness" for each described characteristic.

Peer Drug Involvement. Although many factors can affect youth susceptibility to inhalant abuse, researchers stress that the peer group is almost always one of them, and perhaps the most important one. One's best friend, or small group of friends, forms a drug-using peer cluster in which they share beliefs and ideas, support the rationale for inhalant use, and decide who will use, how much, and when. One stereotype of the heavy inhalant user is that of the social isolate or "loner." Research reports, however, are highly consistent in describing most inhalant abuse as a group activity. The kinds of friends that inhalant abusers have may be an important factor in their inhalant use. Inhalant abusers tend to have a narrower group of friends, most of whom have higher levels of deviance, including the use of other drugs. While family sanctions against inhalant use tend to be high, even in the families of inhalant-using youth, sanctions against inhalant use by peers are much lower.

> *Inhalant abusers seem to disappear from school-based surveys beginning with the eighth grade, most likely because many of these students drop out.*

Family. One of the more frequent research findings is that inhalant abusers suffer from serious family problems. They are more likely to come from broken homes, from families with alcohol and/or drug problems, and from families that are marked by conflict. A number of studies indicate that families of inhalant users have high levels of aggression and/or hostility. When family drug or alcohol use is assessed, the families of inhalant abusers are also more likely to be substance-involved. Inhalant abusers with drug-using families use more types of drugs, perceive their friends as having a more favorable attitude toward drug use, experience more poverty, and are more likely to have parents who have been arrested.

Opportunity. Although inhalant abusers almost uniformly experience family problems that should negatively influence socioeconomic status (SES), studies do not show large and consistent differences in SES. It is possible that very low SES groups may be under-represented in population surveys or in school-based surveys, and therefore these studies may miss the groups lowest in SES and, possibly, highest in inhalant use. Inhalant abusers themselves often show problems with employment.

School. When compared with either non-users or with users of other drugs, inhalant abusers tend to have greater difficulty in school. They are more likely to have high absenteeism, to have been suspended, to drop out or have been expelled, and to have poor academic performance. Furthermore, inhalant abusers seem to disappear from school-based surveys beginning with the eighth grade, most likely because many of these students drop out.

Deviance and Delinquency. As might be expected, since inhalant abusers have trouble adjusting to work and to school, they also have trouble adjusting to society in general. Even compared to other drug users, inhalant abusers stand out as more deviant. Although there are those who prefer inhalants exclusively, the studies that have looked at a range of drug use often find that inhalant abusers are heavily involved with other drugs as well. This heavier involvement with drugs in general may explain why inhalant users have high levels of arrest and probation. Inhalant abusers are also likely to get into trouble with the law earlier than users of other drugs.

Psychological Characteristics. The picture thus far is that inhalant users are a group with serious social and societal problems. A number of studies have suggested that inhalant abusers also suffer from greater emotional distress. Case studies, for example, indicate that inhalant users might be anxious, depressed, more alienated and have lower self-esteem than other drug users. There is consistent evidence that many inhalant abusers have serious personality disorders, specifically antisocial personality disorder and conduct disorder. Co-morbidity with other psychiatric disorders is also common.

Reasons for Use

When inhalant users are asked why they use, some common themes are noted:

1. Desired euphoric effects ("it feels good")
2. Easy availability
3. Low expense
4. Possession is not clearly illegal
5. Convenient packaging
6. Gives fast and multiple highs
7. Adolescent expression or rebellion
8. Easier to hide from or explain to parents than alcohol or marijuana
9. Alleviates stress
10. Peers approve of or insist on use

Discerning the link between expressed reasons for use and behaviors is a complex problem, and is compounded by the drug user's frequent inability to fully recognize or verbalize motives for drug use. One thing is clear from this list, however: The benefits that users perceive outweigh any perceived problems that might arise from their inhalant use.

Effects of Inhalant Use

Intoxication. The reports from most inhalant users indicate that the perceived effects mimic the intoxication produced by alcohol. The initial effects are lightheadedness, tingling sensations, agitation, and a sense of euphoric exhilaration. Further, there is a sense of well-being and power. From these perceptions, one would think that inhalants are stimulants, but prolonged use, as with alcohol, demonstrates that the primary action is one of a physiological depressant. With increased use, effects include dizziness, blurred vision, poor judgment, loss of contact with reality, slurred speech, unsteady gait, and, with a sufficient dose and duration, loss of consciousness. There are some reports that heavy or prolonged doses of inhalants will also produce visual and auditory hallucinations.

Psychological and Social Effects. The social and psychological profiles of inhalant abusers have been described above. They are clearly a troubled group of people with many of their problems likely to have preceded their use of inhalants. In addition to the effects of use already discussed, a major consequence is the exacerbation of existing problems and a hindrance to the ability to resolve them. In particular, the confused thinking caused by inhalants will likely interfere with therapeutic interventions, educational success, or other attempts to maintain a competent lifestyle.

Neuropsychological Problems. From the perceived and observed effects noted above, it is clear that there is some level of impairment due to inhalants in the short term. Additional evidence for this comes from studies of neuropsychological studies of inhalant abusers. For instance, it has been found that inhalant users performed more poorly on a number of neuropsychological tests including IQ, memory, problem solving and various measures of perception than non-users. It should be noted that these studies often do not control for length of abstinence from inhalants, nor for problems that may have existed before inhalants were used.

Neurological Problems. For a number of reasons, there is a modest degree of uncertainty as to the nature of the physical effects of inhalants on neural tissue. First, the high degree of variability and the combinations of chemicals in commercial and industrial compounds make it very difficult to determine a direct effect from any particular chemical. Second, the degree of physical impairment is related to the dose and duration of use, factors that are difficult to ascertain from users. Third, there is the important question of the degree to which physical damage will reverse upon cessation of use. Fourth, it is difficult to sort out problems that may have been in existence prior to the onset of inhalant use. Finally, many studies do not make a distinction between acute and chronic effects. For example, many neurological studies take place while inhalers are intoxicated and draw the conclusion that the effects found will be permanent. It should be recognized that inhalants are lipophilic, which means they are deposited in fatty tissues in the body, such as the brain, and leach out into the blood-stream over an extended period of time. Tests for chronic effects should take place after an extended period of abstinence. Reviews of the existing studies on neurological deficits lead to the following conclusions: While a number of studies have revealed brain abnormalities (e.g., through CAT and MRI imaging), it is not clear whether these were preexisting conditions, that they existed in all inhalant users and whether these problems will reverse over time. A comprehensive review of all the evidence, including that from animal studies, leads to the conclusion that much of the neurological damage is reversible. Some lasting damage does accrue, but it is difficult to detect except in chronic, high-dose users who certainly do exist and should not be dismissed. Based on current knowledge then, there is reason to question the commonly held perception that all inhalant users are incurring severe, irreversible damage, especially light or sporadic users.

Inhalants have not been shown to be addicting in the sense of users exhibiting tolerance and withdrawal, yet the powerful psychological dependence that users report makes it extremely difficult to stop use.

> ***Selecting appropriate, effective and viable prevention efforts is one of the most difficult problems in the inhalant abuse field.***

Non-Neurologic Effects. Other medical problems have been detected among solvent abusers, some of which involve acute crises requiring immediate medical attention. The literature indicates that heart, liver, kidney, blood and lung complications accompany moderate to heavy use of inhalants (not all inhalants cause all of these problems). For the most part, however, once the immediate medical crisis has been managed, these problems tend to resolve with time.

Mortality

Death can occur in at least five ways:

1. Asphyxia (solvent gases can significantly limit available oxygen in lungs)
2. Suffocation (typically seen with inhalant users who use bags)
3. Choking on vomitus
4. Careless and dangerous behaviors in potentially dangerous settings (e.g., explosions and fire)
5. Sudden sniffing death syndrome, most often from cardiac arrest.

The latter of these is of great concern since it can occur among relatively light or occasional, or even first-time, users of inhalants. Death rates are difficult to determine since medical personnel are often not aware that inhalants may have been involved in a fatality.

Prevention of Inhalant Use

Selecting appropriate, effective and viable prevention efforts is one of the most difficult problems in the inhalant abuse field. Prevention efforts must be timely, because of the ever-changing nature of use patterns as well as of the substances abused. Prevention approaches can be thwarted in unanticipated ways; the following problems are the foremost among the many confronting inhalant prevention efforts.

Limited Resources. Because fiscal and personnel resources in many health care systems are limited, attention is directed to the drugs commonly abused by adults. Resources for inhalant research are limited in general, making it even more difficult to fund much-needed (but very expensive and complex) longitudinal studies.

Limiting Availability. In practice, it has been impossible to limit availability of inhalable substances. If legal sanctions are applied to limit the availability of the volatile substance, users will shift to other easily available solvents with potentially more toxic effects.

Criminalization of the User. In some places it is illegal to sell inhalants to minors, or for minors to use inhalants for sniffing purposes. Careful evaluations of such approaches have yet to be made. A report by the World Health Organization concluded, "In general, legal sanctions against inhalant abusers is not a preferred method of prevention. Such sanctions do not appear to reduce abuse and they create additional problems for users." However, given the multiple and complex problems of inhalant abusers, legal approaches may be one avenue for channeling them into treatment.

Chemical Deterrents and Reformulations. Adding deterrents (foul-smelling or irritating substances) to solvents to discourage use is no longer a prime avenue of prevention for at least four reasons:

1. Users would likely switch to other, potentially more toxic solvents if the deterrent were too noxious.
2. The user may not interpret their effects as noxious, or might even like the dare-devil aspects of use.
3. The legitimate uses and users of the substance might be adversely affected.
4. Commercial manufacturers would fear a reduction in product sales. Many of the deterrents that have been explored were deemed too noxious, too toxic, or unstable.

Labeling. While some argue that labeling a product's side effects would deter use and alert parents, others note that product labeling would call attention to products that give a high.

> ***Most inhalant abusers have multiple and serious social and emotional problems.***

Information Dissemination vs. Media Contagion. Since inhalable products are so commonplace, communication about inhalants must walk a fine line between education and suggesting to young people new products and ways to get high. The commonplace "show and tell" exhibits containing examples of inhalable products are to be particularly avoided.

Prevention Goals. Abstinence is the most appropriate message. Inhalants have the potential to kill, even for first-time, naïve users. Harm reduction (i.e., encouraging safe use rather than cessation) should not be encouraged. Most inhalant use takes place at a very young age and a message that says "Use it, but be careful" is inappropriate for this age group. It is one thing to counsel a college student, for instance, about prudent use of alcohol, but quite another to give the same message to a 13-year-old who is already experiencing psychological and social problems, especially given the inherent dangers of inhalants.

Scare Tactics. Scare tactics have never been shown to be an effective deterrent to drug use. Children may not believe exaggerated negative messages since these conflict with their own observations of effects. As a result, children may disbelieve other prevention messages, since the source seems unreliable. Over-reliance on scare tactics may further remove youth from the social fabric and engender disrespect for the law, authority figures and social structures.

Legislative Efforts. Legislative efforts against inhalant abuse are best categorized as semi-interdiction approaches with the aim of keeping the drugs out of the hands of young people. Because of commercial considerations, full interdiction is not feasible. Product-based legislation has included warning labels, use of deterrents, repackaging, and reformulation. Abuser-based legislation has made it illegal to sniff or to be high from sniffing (thus labeling the user as a criminal), and has imposed mandatory treatment for people who are caught sniffing. Supply-based legislation has placed age restrictions on purchasing, made it an offense to sell products to a minor for sniffing purposes, and placed a total prohibition on availability of some products. Credible evaluation of these approaches is very limited.

Conclusions

Inhalant abusers exhibit all the problems experienced by abusers of other drugs plus a significant number that are unique to this class of chemicals. Most inhalant abusers have multiple and serious social and emotional problems and thus have been an enigma to both the prevention and treatment fields. Common perceptions of the use of inhalants run a range from "its just a passing fad, all kids do it" to "abusers are burning out their brains from the very first sniff." These commonly held notions, along with a dearth of adequate research information, make inhalant abuse one of the more perplexing topics in the field. Adequate prevention approaches have yet to be discerned, but it is likely that approaches used with other drugs may be appropriate with the recognition that additional factors accompany inhalant abuse that need to be considered.

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INHALANT USE AMONG YOUTH ACROSS A DECADE: 1990-1999

by Elaine Adams Thompson, Ph.D., RN, Nicole D. Franklin, and Leona L. Eggert, Ph.D., RN, FAAN

Inhalant use has been associated not only with other drug use, but also with chronic and severe medical problems including sudden death. Particularly alarming is the early onset of inhalant use among elementary and middle school youth that continues into the high school years and beyond. Of concern is the ready access that youth have to many inhalant substances because they tend to be common household items, such as glue, paint thinner, office supply solvents, and gasoline.

For the first half of the 1990s, inhalant use appeared to be increasing, particularly among school-aged children and early teens. The National Household Study on Drug Abuse (NHSDA) recently reported a decline from 1997 to 1998 in adolescent past-month inhalant use, from 2.0% to 1.1%. This type of household survey is likely to miss youth at greatest risk for substance use/abuse because they are most difficult, and therefore costly, for survey researchers to locate. Similarly, potential high school dropouts, while still in school, have high truancy rates and are also likely to be missed in school-based surveys. Potential school dropouts are of particular concern because, in contrast to other in-school youth, they are at higher risk for multiple problem behaviors including drug use, aggression, depression, and suicidal behaviors. They also tend to be disenfranchised from school and frequently alienated from their families. This research focuses on this high-risk group of potential school dropouts who show early signs of more serious behavioral and mental health problems.

In this article we describe results from a study in which we examined inhalant use across the past decade. We focus on high-risk youth—potential school dropouts—and compare these youth with others in their school setting.

Methods

Study Samples

A three-group survey design was used to examine inhalant use among youth across the past decade. The design included youth randomly selected to participate in a larger study of high school youth. The sample consisted of 750 high-risk youth and 485 "typical" youth from five urban high schools in the Pacific Northwest. High-risk youth were defined as students at-risk for high school dropout or school failure and were identified using indicators known to predict future dropout, including school record data on academic performance, attendance, prior dropout status, and referrals from school personnel. Typical youth included those not meeting the high-risk criteria. Thus, three samples of high-risk youth were randomly selected from the larger database representing three time periods:

Early (1990-1992, N=250),
Mid (1995-1996, N=250), and
Late (1998-1999, N =250).

The two samples of typical youth were included for the comparison, representing youth in the Early (N=250) and Late-1990s (N=235). No typical youth sample from the mid-1990s was available for these analyses.

Measurement

The *High School Questionnaire: Profile of Experiences* measured drug use, suicide risk and other health risk behaviors. All measures were derived from previously developed scales or constructed for the purposes of the *Reconnecting Youth Prevention Research Program.* Scales were based on a 7-point, Likert-type scale, ranging from 0 to 6. Higher values indicated higher levels of the measured construct. All measures have met standard reliability and validity criteria.

Drug use (inhalants, tobacco, alcohol, and marijuana) during the past month was measured using a 7-point frequency scale ranging from 0 = "never" to 6 = "every day." Suicidal behaviors (threats, attempts) and related risk factors (depression, anger/aggression, self-esteem, self-efficacy) were measured using a 7-point frequency scale ranging from 0 = "never" to 6 = "6 or more times." Background/demographic variables included age, sex, ethnicity, family composition, and number of school moves.

Procedures

Youth were randomly selected and personally invited to participate in the survey by the research staff. University-approved, informed consent ensuring confidentiality and subjects' rights was obtained from each youth, and his/her parent(s) or legal guardian(s). Generally, study acceptance rates were high, ranging from 85-90% across the decade and across schools. The survey was administered by research staff in the school setting. Once completed, youth sealed their survey in an envelope and returned it to the research staff.

> *Whereas overall use of inhalants may appear to be declining, inhalant use has not been significantly reduced among high-risk youth.*

To protect against any possible breach in confidentiality, high school personnel never had access to the questionnaire data. The data were taken to and processed at the University of Washington.

Results/Discussion

Sample

Among the 750 high-risk youth, there were slightly more males (approximately 55%) than females. Among the 485 typical youth, there were essentially equal numbers of male and females. The youth ranged from 14-19, with a mean age of about 16. Overall, the sample was ethnically diverse, with 43% minority representation: Native American (3%); Asian-American/Pacific Islander (14%); African-American (4%); Latino/Hispanic (11%), and Mixed Ethnicity/Other (11%). Compared to the total sample, minority youth were disproportionately represented (51%)

among the at-risk group of potential school dropouts. Also, high-risk youth (42%) compared to typical youth (73%) were less likely to be living with both biological parents. Similarly, high-risk youth compared to typical youth experienced more school disruption due to school moves.

Inhalant Use Across the Decade

Among high-risk youth, the proportion reporting inhalant use during the past month remained stable at 6% (Figure 1) across the decade. This value, however, is considerably higher than the 1.2% reported in the NHSDA report. The slight increase in the proportion of high-risk youth using inhalants from the Early to Late periods was not statistically significant. In striking contrast, the use of tobacco, alcohol, and marijuana declined for high-risk youth, particularly from mid to late periods.

Figure 2 illustrates that proportionally more high-risk compared to "typical" youth use drugs, including inhalants. Examination of inhalant use both early (Figure 2a) and late (Figure 2b) in the decade, revealed a greater discrepancy between high-risk and typical youth in the Late period. That is, among youth surveyed most recently, inhalant use among typical versus high-risk youth was significantly lower, suggesting that prevention efforts may be reaching typical youth, but not youth at greatest risk.

The Association of Inhalant Use and Age

Inhalant use is frequently thought to be a "drug of choice" among younger adolescents. Examining the relationship between age and inhalant use among these high school youth revealed interesting patterns. Of youth reporting inhalant use within the past month, most users were either younger than 16 (36-47%) or in the 16-17 year range (43-55%). This was true for both high-risk as well as typical youth and was true in both the early part of the decade and late in the decade. Youth 18 or older were least likely to use inhalants; less than 14% of inhalant users were 18 or older. What is striking about these findings is the relatively high proportion of inhalant users who were 16-17 years, a time when inhalant use is generally thought to decline.

Inhalant Use and Health Risk Behaviors

Of particular interest is the degree to which inhalant use is associated or clusters with other adolescent health risk behaviors. Focusing on both high-risk and typical youth currently in high school, the analyses revealed that inhalant use was associated with other drug use, including alcohol and marijuana. In particular, there were moderately strong associations between inhalants and opiates and depressants. Inhalant use was associated with low self-esteem and low self-efficacy. Consistent was the finding that inhalant use

Figure 1
High-Risk Youth Inhalant Use Compared with Other Drug Use: 1990-1999

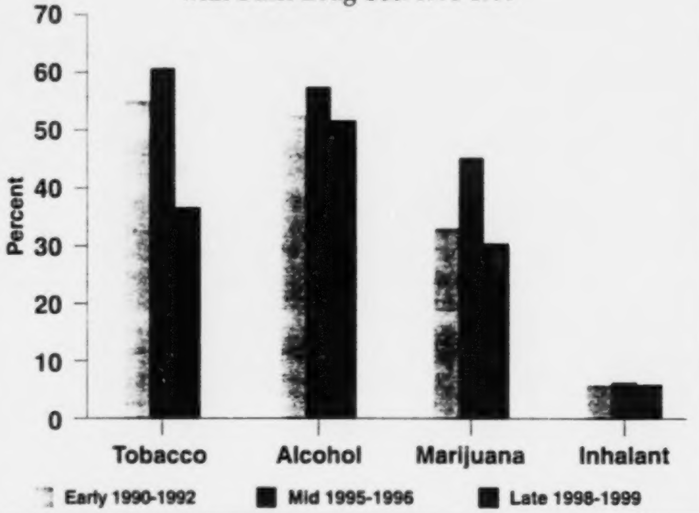
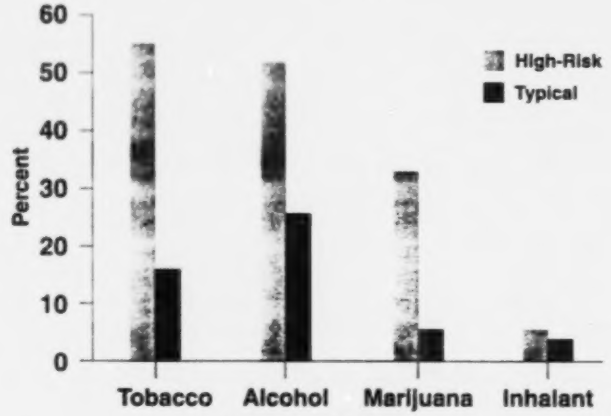
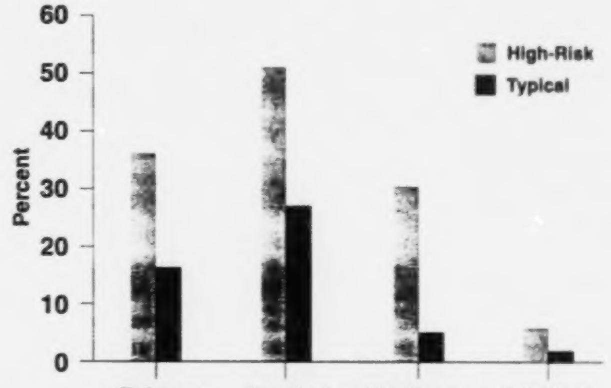


Figure 2
High-Risk vs. Typical Youth: Comparison of Inhalant Use and Other Drug Use Early (2a) and Late (2b) in the Decade



2a Early: 1990-1992



34

2b Late: 1998-1999

was also associated with depression, hopelessness, and importantly, with suicidal behaviors including suicide threats and suicide attempts. The association between suicidal behaviors and inhalants was stronger than with any other drug type. This suggests that inhalant use forecasts other adolescent health risk behaviors. Given the inherent dangers with inhalant use and the dire risk of suicidal behaviors, these findings signal the need for targeted prevention efforts to curb inhalant use among youth.

While results from the recent NHSDA study—showing declines in inhalant use among the general adolescent population—are encouraging, the findings reported here suggest that it may be premature for parents, schools, and communities to relax concerns regarding inhalant use among youth. Whereas overall use of inhalants may appear to be declining, inhalant use has not been significantly reduced among high-risk youth. Given that the effects of inhalant use are extremely serious, often irreversible, and potentially lethal, this should be of utmost concern to parents and professionals working with teens.

It is essential to identify high-risk groups for "indicated" prevention efforts. Importantly, this research demonstrates that "high-risk" youth can be readily identified within the school context, allowing for early delivery of preventive interventions prior to the escalation of school difficulties and related health risk behaviors.

Elaine Adams Thompson, Ph.D. is an adolescent psychosocial nurse and nurse researcher with extensive experience in survey research and experimental design. She is a Research Associate Professor in the Department of Psychosocial and Community Health at the University of Washington and co-principal investigator of the *Reconnecting Youth Prevention Research Program.* Dr. Thompson has expertise in implementation and outcome evaluation of large field-based prevention programs and statewide prevention programming.

Nicole D. Franklin is a senior student at the University of Washington, with a triple major in sociology (honors), statistics, and mathematics. She has received fellowships from the Mellon Research Foundation and from the BRIDGES[4] program enabling her to gain field research and data analysis experience. Upon graduation in June 2001, Ms. Franklin will pursue a doctoral degree in sociology.

Leona L. Eggert, Ph.D. is the Spence Endowed Professor in the Psychosocial and Community Health Department at the University of Washington. She is Principal Investigator of the *Reconnecting Youth Prevention Research Program.* This program of research focuses on testing school-based models for preventing drug abuse, school dropout, depression and suicide behaviors among high-risk youth, involving partnerships between school personnel, youth and parents. Dr. Eggert is the author of *Anger Management for Youth: Stemming Aggression and Violence.* She is also a co-author of *Reconnecting Youth: A Peer Group Approach to Building Life Skills*, as well as numerous journal articles and book chapters related to her work with adolescents.

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DRUG RELATED STREET TERMS AND SLANG WORDS FOR INHALANTS*

Aimies – amyl nitrite (also amphetamine)
Air Blast – inhalant
Ames – amyl nitrite
Amys – amyl nitrite
Aroma of Men – isobutyl nitrite
Bang – inhalant (also to inject a drug)
Bolt – isobutyl nitrite
Boppers – amyl nitrite
Bullet – isobutyl nitrate
Bullet Bolt – inhalant
Buzz Bomb – nitrous oxide
Climax – isobutyl nitrite (also crack; heroin)
Glading – using inhalant
Gluey – person who sniffs glue
Hardware – isobutyl nitrite
Heart-On – inhalant
Hippie Crack – inhalant
Honey Oil – ketamine; inhalant
Huff – inhalant
Huffer – inhalant abuser (of gas, glue, pam, etc.)
Kick -- inhalant (also getting off a drug habit)
Laughing Gas – nitrous oxide
Locker Room – isobutyl nitrite
Noss – a term for nitrous oxide
Oz – inhalant
Pearls – amyl nitrite
Poppers – isobutyl nitrite; amyl nitrite
Quicksilver – isobutyl nitrite
Rush – isobutyl nitrite
Rush Snappers – isobutyl nitrite
Satan's Secret – inhalant
Shoot the Breeze – nitrous oxide
Snappers – isobutyl nitrite
Sniff – inhalant; methcathinone (also to inhale cocaine)
Snort – use inhalants (also to inhale cocaine)
Spray – inhalant
Thrust – isobutyl nitrite
Toilet Water – inhalant
Toncho – octane booster which is inhaled
Whippets – nitrous oxide
Whiteout – isobutyl nitrite

* The "meanings" of drug slang may vary widely between neighborhood, city, region and country. There are no "absolutes" with drug slang definitions. The definitions here are provided *only for background and guidance* and should **not** be considered as "authoritative."

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SOLVENT USE, SCHOOL ATTENDANCE, GENDER & ETHNICITY

By Pamela Jumper-Thurman, Ph.D., Scott Bates, M.S., and Barbara Plested, M.S.

Much attention has been focused on the use and abuse of solvents over the past decade; however, solvents have a long and well-established history. Inhalant use was reported as early as the time of the Greek oracles and history suggests heavy use of incense and perfumes in religious and other ceremonials as intoxicants. There are also records from centuries past of "ether-drinking" in England and Ireland as well as nitrous oxide parties in England. Use has even been reported by the Australian aborigines, who, in the 1950s, engaged in petrol sniffing. Until about 1960, use of solvents as intoxicants generally occurred primarily among adults. The phenomenon of solvent abuse by younger children probably began in the 1950s. There are speculations that it may have started in the U.S. as part of the general pattern of increasing use of psychoactive substances. Solvent use by children gained attention as "glue sniffing" and was reported widely by the media. It was also speculated that this attention may have contributed to greater use. Then, over the past four decades, solvent use among youth has spread until it is now considered to be a problem shared by many countries. It is occurring everywhere, rural as well as urban, by both males and females, and across ethnicities.

> *Solvents are the only class of drug that is not defined chemically, but by route of administration.*

Death and Physical Damage From Solvents

Death and physiological damage from solvents has been well established. Early anecdotal reports from the field suggested that children who had been using solvents regularly were suffering brain damage; however, these reports were often difficult to substantiate. Part of this is because chronic solvent abusers are likely to be people who have other serious problems as well. Therefore, it is difficult to sort out physiological and neurological problems that were present prior to solvent use and those occurring as a result of use while the issue of degree of reversibility of damage continues.

There is no question, however, that solvents can produce damage. There is considerable evidence from animal studies and from occupational exposure showing serious damage and death from either extremely high one-time exposure or from chronic exposure at lower levels. There have also been a number of reports of death or injury resulting from the toxic effects of solvents and these, too, have more recently received wide news coverage. Accurate figures of physical damage are hard to obtain because of problems in determining the extent of solvent exposure and isolating it from exposure to or use of other substances. Because so many different chemicals are used and because many abused substances include more than one volatile component, it is difficult to define a specific damage syndrome. Solvent use has, however, been linked to neurological damage and to damage to the liver, heart and circulatory system. Certainly it is reasonable to conclude that solvents are dangerous and that prevention of solvent abuse is an important undertaking.

Solvent Use Among Students

Solvents are the only class of drug that is not defined chemically, but by route of administration. However, many substances that are inhaled are not classified as solvents, such as tobacco, marijuana and crack smoke, crank, cocaine, and heroin powder. Studies on the level of solvent use among children reach the same general conclusions—a significant proportion of younger children are using solvents. By the fourth grade, about 6% of U.S. children have tried solvents. As they get older, a few more try solvents every year until use peaks at about 17% in the eighth grade. From there, lifetime prevalence declines with each successive grade.

Solvent Use and Academic Preformance

There is a strong consistent relationship between low grade point average and solvent use. At almost all grade levels, solvent users are mostly "D" or "F" students. Some researchers have compared the grade point averages of American Indian non-users, one-time users, and repeat users of volatile solvents and found that non-users attained higher grade point averages than one-time users and repeat users—surprisingly, there were no significant differences between grade point averages of one-time users and repeat users. Other characteristics of volatile solvent abusers—related to poor academic performance—have also been reported through various research studies (see recommended reading list at www.TPRonline.org):

- More lifetime users than non-users of volatile substances believe that their school life is rather unpleasurable or completely unpleasurable.
- Non-users were more likely to participate in school activities than lifetime users.
- Students who do not expect to graduate are more likely to have used solvents and have done so in the past six months when compared with students who do expect to graduate. The rate of solvent use drops as a student's education level rises; students who had not completed primary and secondary education had the highest use rates.
- There is also a significant correlation between the grade level completed when a student drops out of school and past use of drugs—the earlier an individual drops out of school, the more likely he/she is to have used drugs.

Comparing a sample of high school dropouts with a random sample of tenth, eleventh, and twelfth graders, researchers Winburn and Hays found that dropouts (18.2%) had tried solvents more than any of the three cohorts (13.2%, 11.9%, and 11.5%, respectively). They also found that dropouts had higher six-month prevalence use rates than the tenth through twelfth grade cohorts.

Method

In the mid-1990s, Bates and colleagues conducted a survey study using participants age 12 to 21 with an average age of 16.5. The total sample (N = 3,416) was 53.4% male and 46.6% female and included an American Indian sample, a Mexican-American sample and a White American sample. Furthermore, three enrollment status categories were identified: dropout, academically at-risk (enrolled), and control. Measures were used that directly investigated solvent use.

Results

Table A shows lifetime prevalence rates for volatile solvent use by ethnicity, gender, and enrollment status. Across both gender and ethnicity, there were significant differences for enrollment status. High school dropouts were 2.27 times more likely than control respondents to have used volatile solvents in their lifetime, academically at-risk respondents were 1.72 times more likely than control subjects to have used volatile solvents in their lifetime, and dropout participants were 1.32 times more likely than academically at-risk respondents to have used volatile solvents in their lifetime.

The interaction between gender and ethnicity was analyzed. For both Mexican-American and White American respondents, a higher proportion of males than females reported lifetime use. However, for American Indian respondents this difference was reversed: For the American Indian cohort sampled, a higher proportion of females reported use of volatile solvents at least once in their lifetime.

> *A higher proportion of the dropout cohort had used solvents, used solvents regularly, and used solvents with more intensity than either the academically at-risk group or the control group.*

Conclusions

Bates found that a higher proportion of the dropout cohort had used solvents, used solvents regularly, and used solvents with more intensity than either the academically at-risk group or the control group. Most of these findings were consistent with previous research findings. Certainly, it is apparent that a relationship exists between enrollment status and volatile solvent abuse—students who drop out of school are more likely to have ever used volatile solvents than those in-school, and thirty-day prevalence rates show that dropouts are more likely to be currently involved with volatile solvents than control subjects.

This research firmly established the relationship between enrollment status and volatile solvent abuse across three ethnic groups using the same methodology. Indeed, for all ethnic groups, academically at-risk youths were 1.72 times more likely than controls to have used solvents during their lifetime and were 2.21 times more likely than controls to have used solvents during the past 30 days.

The interaction between ethnicity and gender, indicating that American Indian females have higher rates of volatile solvent use than males, is an important finding because it counters what was found in other groups. It has been suggested that solvent users, in general, have been found to have higher rates of dysfunction in other areas and it may be that American Indian females are being subjected to a wider array of environmental stressors, resulting in higher use being more acceptable for females in this population. It may also be suggestive that American Indian females who are involved in deviant behaviors are more prone to involve solvent use in that lifestyle, thus raising the potential of fetal effects and other health risks. Regardless, the complexity of this issue would seem to encourage a wide range of potential factors that results in questions that certainly need further investigation. How might American Indian female profiles and use patterns differ from males? Are their peer dynamics different? Most risk factor studies have utilized male samples or reported results using combined samples of males and females—perhaps an in-depth risk factor study should be completed exclusively on American Indian females.

Longitudinal studies, though fewer and more difficult to conduct, would prove helpful in identifying the predictors of solvent abuse and the outcome of such abuse. For instance, longitudinal studies might further examine the intricacies of the variables that lead to, are associated with, or are outcomes of volatile solvent abuse. Current research indicates a definite relationship between poor academic performance, dropping out and volatile solvent abuse; however, the direct and causal nature of those relationships remain unclear.

Table A

Percentage of Respondents Indicating Lifetime Prevalence for Volatile Solvent Use

	Dropouts	Academically At-Risk	Controls
Mexican-American Male	37.3%	29.8%	19.7%
Mexican-American Female	28.1%	22.3%	14.8%
White American Male	46.1%	32.8%	28.8%
White American Female	28.6%	31.3%	18.8%
American Indian Male	34.5%	32.0%	11.7%
American Indian Female	40.2%	32.6%	23.9%

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RESOURCES

National Clearinghouse for Alcohol and Drug Information
www.health.org
800-729-6686

Prevline, the Web site for the National Clearinghouse for Alcohol and Drug Information (NCADI), includes a large list of inhalant-related information. Information on this site includes links to the "Mind Over Matter" series, which is designed for youth in grades five through nine and which discusses the brain's response to a variety of drugs. Included in the Mind Over Matter series is a teacher's guide (available online and in .pdf printable format). Prevline also has an attractive and informative Parents Guide. The video "Educate: Creating Inhalant Abuse Awareness Together" is available for viewing online, or may be ordered through the toll-free number.

National Inhalant Prevention Coalition
www.inhalants.org
800-269-4237

The National Inhalant Prevention Coalition (NIPC) is an inhalant referral and information clearinghouse. It is funded in part by the Robert Wood Johnson Foundation. The NIPC Web site includes information about what products can be abused (including products typically found in schools), characteristics of an inhalant user, including the signs and symptoms of a long-time user, and tips for teachers. This site is rounded out with an extensive list of links for more information.

UPCOMING TOPICS

Self-Injury

Also called self-mutilation and self-inflicted violence, self-injury is the intentional harming of one's own body without suicidal intent. Cutting is the most common form of self-injury, but burning or hitting oneself are also methods. Dr. Armando Favazza, the most prominent researcher in self-injury, estimates the number of sufferers at 750 per 100,000 Americans. Self-injury typically begins in adolescence, and commonly affects teenage girls. Volume 7(4) of *The Prevention Researcher* will delve into this little-known and poorly understood behavior.

Gay, Lesbian and Bisexual Youth

Exact estimates of the number of high school youth who self-identify as gay, lesbian or bisexual are hard to determine. It has been estimated that 9 students in 30 are directly affected by these issues, either by having a gay or lesbian parent, sibling or relative, or being gay themselves. Gay, lesbian and bisexual students have shown to have higher rates of suicide and substance abuse and are disproportionately represented in the street youth population. Volume 8(1) of *The Prevention Researcher* will examine the ways in which counseling, school, and social service professionals can assist this largely invisible population.

Tobacco Use

Despite recent declines in cigarette use, according to the 1999 Monitoring the Future data, almost a quarter (23.1%) of high school seniors reported daily cigarette use. Examining use in the past thirty days, 34.6% of the seniors had smoked (35.4% of the males and 33.5% of the females). White twelfth graders report the highest cigarette use (40.1% in the past 30 days) compared to 27.3% of the Hispanic students and 14.9% of the African-American students. Volume 8(2) of *The Prevention Researcher* will focus on adolescent tobacco use.

Other Future Topics Include:

- Street Youth
- Teenage Depression
- Involving Parents in Prevention and Intervention

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SELF-MUTILATION

By Karen L. Suyemoto, Ph.D. and Xóchitl Kountz, M.S.

For over 65 years psychologists have studied self-mutilation. This research has resulted in a large amount of information about the prevalence; phenomenology; associated characteristics, symptoms, diagnoses, and experiences; and the function and treatment issues of self-mutilation.

Definition

The definition of pathological self-mutilation needs to take into account a number of issues:

1. *Directness:* Pathological self-mutilation is direct. It differs from indirect self-harm such as drinking and driving.
2. *Social acceptability:* Pathological self-mutilation is socially unacceptable, even within most social subcultures. It differs from more socially acceptable bodily harm such as ear piercing or tattooing.
3. *Frequency and degree of damage:* Pathological self-mutilation is repetitive and results in minor or moderate harm. It differs from major self-mutilation or extreme self-inflicted bodily harm such as the removal of one's eye or self-castration. These extreme behaviors are usually single instances, clearly more severe, and usually associated with some form of psychosis.
4. *Intent:* Pathological self-mutilation does *not* have the intent of suicide. It differs from suicidal gestures and acts in the client's perception of the event, the stated reason for the behavior, and the associated features.
5. *Psychological state:* Pathological self-mutilation is not related to cognitive impairment. It differs from the stereotypical behavior of self-injury that is often seen in mentally retarded or autistic children in the intent of the behavior, the underlying dynamics, and associated developmental and psychological experiences.

> *The definition of self-mutilation is that it is a direct, socially unacceptable, repetitive behavior that causes minor to moderate physical injury.*

The definition of self-mutilation that fits the best with the majority of studies is that it is a direct, socially unacceptable, repetitive behavior that causes minor to moderate physical injury. When self-mutilating, the person is in a psychologically disturbed state but is not attempting suicide. The self-mutilating person is not mentally retarded or autistic nor engaging in a stereotypical behavior associated with these diagnoses.

Prevalence

The actual number of people per year who self-mutilate is difficult to assess, as is the number of individuals who self-mutilate at some time during their

FROM THE EDITOR'S PC

Dear Colleagues:

This issue of *The Prevention Researcher* is devoted to a topic which does not get much attention in the prevention literature. However, it is a serious and pervasive problem, especially among a growing number of teens.

This volume focuses on SELF-INJURY, specifically cutting, burning and otherwise harming one's body through self-inflicted wounds. We first became aware of this behavior and its destructive outcomes by a feature article in the *New York Times Magazine* in July of 1997. Since then, it has received more press and researchers are starting to understand it better.

Our guest authors are: Karen Suyemoto, Ph.D., at the University of Massachusetts Department of Psychology; Tracy Alderman, Ph.D., in private practice in San Diego, California; and Dr. Angela Favaro, of the eating disorders unit of the University of Padova, in Italy. We thank all of our contributors; we believe this is an outstanding issue with some very important and up-to-date material on the characteristics and functions of self-injury.

As always, visit our web site at www.TPRonline.org for information about upcoming topics, citations, comments, and a look at our new search engine.

All the best,

Steven Ungerleider, Ph.D.
Psychologist/Editor

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lifetime. Some studies on self-mutilation have included a wide variety of self-harming behaviors including suicidal acts and other types of self-harm, such as poisoning, leading to overestimates. Other studies have included only one type of self-mutilation, such as cutting or burning, leading to underestimates. Past studies may also have underestimated the prevalence of self-mutilation by gathering data primarily from police reports, doctors' records, or hospital files. This method tends to count only severe cases requiring legal or medical interventions, and overlooks the many cases of self-mutilation that cause only minor or moderate harm and which are self-treated. Therefore, estimates of self-mutilation in the general population range widely from 14 to 600 per 100,000 annually. With a United States population of approximately 260 million, this means between 36,400 and 1,560,000 people engage in self-mutilation each year. Rates seem to be higher in adolescents and young adults, ranging from 1,800 per 100,000 in people aged 15 to 35 to a high of 12% in a general college student population.

In psychiatric populations, the prevalence of self-mutilation is much higher, ranging from 4.3% to 20% of all psychiatric inpatients. Rates among adolescent inpatients range from 40% to 61%. A survey of outpatient therapists found that 47% had seen at least one self-mutilating adolescent.

Phenomenology

There is a surprising amount of agreement in the self-reported experience of self-mutilation. The event that precipitates the self-mutilation is usually the *perception* of an interpersonal loss, such as an argument or a counselor's vacation. Self-mutilators often report that they feel extremely tense, anxious, angry or fearful right before self-mutilating. Often, but not always, the person reacts to the over-whelming emotion by dissociating. Isolation from other people almost always occurs before the actual act of self-mutilation. Self-mutilating is usually quite controlled and, by definition, the intent is not suicide. Self-cutting is the most common type of self-mutilation. The most often used tool is razor blades and the most common places for self-mutilation are the wrists and the forearms. Most people who self-mutilate state that there is no pain during the actual mutilation. Although self-mutilators sometimes report feeling guilty or disgusted after an incident, most people report feeling relief, release, calm, or satisfaction. The self-mutilating behavior usually ends the anger, tension, or dissociation.

Self-cutting is the most common type of self-mutilation.

Characteristics, Diagnoses & Other Experiences

Research suggests that people who self-mutilate are most often single and female. There is little data on ethnic, racial, or class variables. The first time a person self-mutilates is usually in middle to late adolescence, and they are usually initially seen in treatment during these ages. Self-mutilators are more likely to be underemployed, and have a lower achievement in their occupations relative to their educational background than people who do not self-mutilate.

Self-mutilation occurs most often in conjunction with a diagnosis of borderline personality disorder. Some studies report that self-mutilation is associated with more severe character pathology. However, the fact that the majority of studies on self-mutilation use inpatient populations has most likely biased these results toward clients that are more severely disordered to begin with.

Other diagnoses associated with self-mutilation include: major depression, minor depression, dissociative identity disorder, obsessive-compulsive disorder, alcoholism and other substance abuse, eating disorders, schizophrenia, anxiety disorders, and several personality disorders.

It may be very difficult to correctly diagnosis a client whose main presenting symptom is self-mutilation. These clients may exhibit some of the criteria for one specific diagnosis, while differing greatly from the other associated criteria. The tendency to almost automatically diagnose self-mutilators with borderline personality disorder (because self-mutilation is one of the specific diagnostic criteria), may increase the difficulty of accurate diagnosis.

The first time a person self-mutilates is usually in middle to late adolescence.

There is some call for a separate "Deliberate Self-Harm" diagnosis. Dr. A. R. Favazza argues that repetitive self-mutilation is an impulse disorder, occurring frequently with other impulse disorders, such as eating disorders and kleptomania. He argues that the association of self-mutilation with personality disorder diagnoses is not valid, as people rarely fit the criteria for a personality disorder (a disorder that is hypothetically stable) once the self-mutilation ends. Drs. Kahan and Pattison present an extensive argument for an independent diagnosis of deliberate self-harm. They state that deliberate self-harm is unique and can be differentiated from other diagnoses in its specific characteristic symptoms, course, prevalence, population, predisposing factors and differential diagnosis criteria.

Self-mutilation has been associated with a variety of other psychological symptoms including antisocial behavior, increased suicidal ideation, increased past suicide attempts, anger, anxiety, and symptoms of depression. However, the associations between self-mutilation and anger, anxiety, and symptoms of depression are not always supported. Most research has also supported the expected (given the phenomenological experience) association between dissociation and self-mutilation. However, Drs. Langbehn and Pfohl found no association and Drs. Zweig-Frank, Paris, and Guzder found that the association between dissociation and self-mutilation was primarily due to the association between borderline personality disorder and self-mutilation. Although the fact that self-mutilation is a diagnostic criteria of borderline personality disorder complicated their findings, their additional finding of no differences in dissociation between borderline personality disordered patients who self-mutilate and those who do not self-mutilate points to the need for further investigation of the relationship between dissociation and self-mutilation.

Self-mutilation has also been associated with some physical and sexually related difficulties. These include an increased number of physical illnesses and complaints, current sexual dysfunction, and high-risk sexual behavior, especially behavior that increases risk for HIV. Research also suggests that clients who self-mutilate often have more extensive treatment histories than other clients who are diagnosed with personality disorders, or clients who attempt suicide.

In terms of family and developmental background, self-mutilators are more likely to come from families characterized by divorce, neglect, or deprivation of parental care. Simpson noted in an early review that while suicidal patients tend to have childhood experiences of complete parental loss due to death or divorce, people who self-mutilate more often experience partial parental loss due to emotional distancing from parents and inconsistent parental warmth. Individuals who self-mutilate often have a history of childhood sexual or physical abuse. However, similar to their analysis of self-mutilation and dissociation, Dr. Zweig-Frank and colleagues found that the diagnosis of borderline personality disorder accounted for the relationship between self-mutilation and child abuse. In addition, they found that a history of child abuse did not differentiate between clients with borderline personality disorder who self-mutilated and those who did not self-mutilate. In general, greater attention to the interaction of diagnosis, behavior, and past experience is needed in studying experiences associated with self-mutilation in order to better understand their contributing roles and best facilitate change.

Youth who self-mutilate may choose this behavior because it meets a multitude of needs at one time.

Functions of Self-Mutilation

Youth who self-mutilate may choose this behavior because it meets a *multitude* of needs at one time. The most common functions of self-mutilation reported by clients and practitioners are: expressing and controlling overwhelming emotions, and maintaining a coherent sense of self when threatened with the loss of identity.

Self-mutilation is an active, direct, concrete representation of intense anguish. When people who self-mutilate experience a perceived abandonment, they are overwhelmed by emotions. These emotions may include: (a) pain from the perceived rejection (see Phenomenology above); (b) anger at the self for neediness leading to the rejection; (c) fear and pain because they perceive that a significant other (such as a partner, friend, or counselor) is angry; they not only fear the anger itself, but also believe the anger has led to the rejection and are fearful and hurt by the withdrawal of affection; and (d) anger at the significant other for the rejection; the person may feel frightened by being angry at the significant other (fearing rejection as well as the possibility of hurting the other person with the anger) and may therefore redirect the anger from the significant other onto the self.

Self-mutilators characteristically have difficulty verbalizing emotions and distancing from feelings. Self-mutilation enables the youth to turn the passive emotions that come from being abandoned into an active, physical event that can be externalized and controlled. Thus, self-mutilation is used to communicate the intensity of their pain and create physical evidence of their emotional injury so they may feel that their emotions are real, justified, or able to be tolerated.

Self-mutilation is an active, direct, concrete representation of intense anguish.

Self-mutilation may also be chosen because it helps maintain a stable sense of self. The neediness of self-mutilators can create feelings of merging with a significant other, including feeling as if one is losing one's own separate needs, emotions, and sense of self. Because self-mutilators may feel encased in the experience of the significant other, their perceived loss of the significant other (see Phenomenology above) is experienced as a loss of self. Self-mutilation can serve to create an active boundary between the self and the other person, as well as between the inner dissociation and the outside world. The blood and the scars serve as concrete reminders of these separations, boundaries, and the resulting sense of an independent self. Self-mutilation reaffirms the most basic boundary of the flesh, the first boundary that contributes to the beginnings of a sense of self in infancy. The boundary between self and other that occurs with self-mutilation may also be reinforced by using self-mutilation to create a separate and unique sense of self in other people's view. Other people may identify the person as a "cutter" or "self-mutilator," turning the behavior into an identity that can be differentiated from others.

Treatment Issues

Treating self-mutilators can be very difficult. Most treatment reports focus on psychodynamic interventions and issues. The most helpful aspects of therapy seem to be increasing the patient's ability to verbalize and express emotion; and addressing the difficulties of maintaining a stable sense of self. Strategies related to expressing emotions include: increasing the ability to cope with and accept feelings (especially anger and sexual feelings); increasing verbal or other symbolic expression of feelings (e.g. art); and developing insight into the meaning and function of the self-mutilation itself, perhaps contributing to the ability to distance from feelings. Strategies related to maintaining a stable sense of self involve creating a positive relational experience within the therapy relationship, which may involve a certain degree of merger in order to enable a separation process. The intensity of this type of relationship frequently produces strong countertransferential reactions within the practitioner, including viewing the client and the self-mutilation as deliberately hostile or manipulative. Practitioners frequently treating clients who self-mutilate may want to seek peer support.

Self-mutilation is an extremely complex behavior. While we have significant research and theory contributing to an understanding of the phenomenology and associated behaviors, we have less agreement and knowledge about the reasons behind self-mutilation and the best way to treat it. This may be because self-mutilation is an overdetermined behavior, serving many functions and purposes simultaneously. The choice of coping strategy and expressive behavior may be related to how a certain behavior meets a variety of needs, both general human needs (e.g. emotional regulation) as well as aspects specifically related to the individual (e.g. specific boundary issues). Understanding the phenomenology, characteristics, associated symptoms, and family experiences of clients who self-mutilate may help us to contextualize the behavior and better understand why an individual might choose this behavior to try to meet these needs.

Karen Suyemoto, Ph.D. is an assistant professor in the Psychology Department at the University of Massachusetts at Boston. This article is abstracted from an article that was originally based on her dissertation research at the University of Massachusetts, Amherst.

Xóchitl Kountz is a recent graduate from the Master's program in Counseling Psychology at Northeastern University (Boston, MA) with a special interest in trauma and its sequelae.

This article is condensed from K.L. Suyemoto (1998). The Functions of Self-Mutilation, *Clinical Psychology Review*, 18(5), 531-554. Copyright 1998, with permission from Elsevier Science.

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SELF-INJURY OR BODY MODIFICATION?

By Gina Ng

The growing awareness of self-injury comes at a time when body modification, such as tattooing and body piercing, is becoming popular (see Volume 5[3] of *The Prevention Researcher*, Fall 1998). Body modification is especially frequent among teenagers.

Extreme body art is also becoming popular today. This form of body modification involves scarification and branding. Scarification occurs when a person cuts his or her skin, then he or she may even prevent the body's healing process to enhance the scars. Branding involves heating metal that has been twisted into a design, then pressing it quickly and firmly onto the skin. The purpose of both scarification and branding is to create a decorative scar.

An increasing number of people are choosing extreme body art to express their individuality. For example, it is common in some fraternities in the United States for members to be branded. Fraternity members believe that branding creates a feeling of brotherhood.

The increasing popularity of these practices has led many people to wonder if there is a difference between self-injury and body art. The main difference between self-injury and body art is a person's reasons for choosing to alter his or her body. People who injure themselves are usually trying to make themselves feel better by hurting their bodies. They often do this secretly and are ashamed of their actions. In contrast, many people who practice scarification or branding do it to make a statement. They want to be unique and set apart from the mainstream. They often proudly show their scars to others, rather than hiding them or covering them.

Another important difference between body modification and self-injury is control. Most people make a conscious decision, and think long and hard, about an extreme body art. However, people who self-injure are often unable to control their urges. They have to cut or hurt themselves to cope with daily problems in their lives.

Excerpt condensed from *Everything You Need to Know About Self-Mutilation: A Helping Book for Teens Who Hurt Themselves* by Gina Ng. Copyright 1998 by Rosen Publishing Group, Inc., 29 East 21st Street, New York, New York 10010.

HELPING THOSE WHO HURT THEMSELVES

BEST COPY AVAILABLE

By Tracy Alderman, Ph.D.

If you work with youth, it's likely that at some point you will come in contact with someone who self-injures. This article is intended to provide some support, advice, and education to those who have students or clients who engage in activities of self-inflicted violence.

What You May Feel

Shock and Denial

Because self-inflicted violence (SIV) is a secretive behavior, it can be shocking to learn that someone you know is a self-injurer. You may not have noticed many of the signs of SIV, such as a refusal to wear shorts or short-sleeved shirts, even on the warmest of days. You probably gave no thought to the frequent "accidents" or the numerous bruises and cuts on the arms and legs of a student which were always accounted for by a logical source. Self-inflicted violence lends itself to secrecy quite well—it usually takes place in isolation and the results can be concealed with relative ease. Also, most people are often eager to ignore or deny many of the telltale signs of this behavior. Thus, when you find out about self-injurious behavior, it is shocking.

Denial is related to the shock. At times, denial is appropriate, useful, and necessary. However, with self-inflicted violence denial is detrimental. People who injure themselves are in a great deal of psychological distress. To deny this distress will communicate that you are not interested, not able to help, or do not understand their SIV behaviors. When you are confronted with self-injurious behavior it is important you do not deny the reality and implications of the situation. Although this may be difficult, responding to the SIV, rather than denying its existence, is necessary in order to aid those individuals who are injuring themselves.

Anger and Frustration

Anger is a common response when learning of an individual's self-injurious behavior. There are many reasons for this. First, anger may stem from the deception which often surrounds SIV. Many individuals who hurt themselves lie about the causes of their injuries. Deception is used as a way of reducing feelings of shame and warding off possible reactions of anger, disgust or rejection from others. However, when the deception is discovered it often produces those very same feared reactions.

Additionally, believing that the self-inflicted violence was not necessary may also anger you. Watching individuals do things to physically damage themselves is frustrating. You may be inclined to scold them or force them to stop hurting themselves. Frustration stems from our inability to control the behavior of others.

Self-injury, as opposed to many other self-damaging behaviors, usually produces visible, physical evidence. This evidence forces us to realize the extent of our helplessness in changing the individual's behavior, causing us frustration and anger.

Empathy, Sympathy and Sadness

Empathy is often a mixed blessing. On the one hand, it allows you to be more helpful while also causing you to feel similar sadness and psychological pain as the individual with whom you are dealing. Individuals who engage in self-inflicted violence experience enormous psychological distress. It is essential to understand the immense nature of this distress, providing support and assistance. However, by doing so, you run the risk of allowing that person's inner world to penetrate you. The result of our inability to remain detached is that you may feel some of their sadness and pain.

We may also feel sad for the individual who is performing self-inflicted violence. However, feeling sympathetic towards others may cause you to see them as figures worthy of our pity. In many ways, this is condescending. While empathy is helpful, sympathy is not. Individuals who hurt themselves may view their SIV as a positive action, an action which helped them to survive. Being sympathetic, you may see their SIV as a negative and pitiful behavior, an act of desperation. Thus, sympathy is not particularly useful.

Guilt

Self-inflicted violence often provokes feelings of guilt for those who are close to the individuals performing these behaviors. You may feel as if you did something wrong which caused this person to self-injure. Perhaps you may think you weren't the best teacher, parent, or friend. Guilt can be a useful emotion, but in the case of SIV, it is often not appropriate, necessary, or useful.

It is more helpful to surpass these feelings and focus your energy in a more positive and useful direction. Talk with the self-injuring student and find out how you can be helpful at this point in time. Wallowing in your own guilt will keep you immobilized instead of becoming an active and helpful participant.

> *Self-inflicted violence usually takes place in isolation and the results can be concealed with relative ease.*

What You May Think

A variety of thoughts commonly accompany the knowledge that someone you know is performing SIV. Some of the more common are:

- It's all my fault.
- I can fix this.
- You're nuts!
- This changes our whole relationship.
- You're not who I thought you were.
- You're doing this to manipulate me.

Considered objectively, many or all of these thoughts are erroneous and could easily negatively influence your feelings. It is important to be aware of your thoughts so you can prevent them from influencing negative emotional responses which could damage your relationship with the self-injurer.

What To Do and Not Do

We don't like to see others in pain. It is almost instinctual that we try to end another's misery. When we see students or clients injuring themselves, we begin to understand the enormity of their psychological pain, and it is only natural that we want to help. However, without the proper education and training, helping could do more damage than good. This section will provide some idea of what you should and should not do when trying to assist those individuals who are injuring themselves.

Talk About Self-Inflicted Violence

As mentioned previously, SIV is surrounded by shame and secrecy. SIV exists whether you talk about it or not. Ignoring something does not make it disappear. The same is true with self-inflicted violence: it will not go away by pretending it does not exist.

Avoiding SIV has several negative effects. First, it reinforces and strengthens the feelings of shame attached to this behavior. Individuals engaging in SIV may get the idea that the behavior is so shameful that even talking about it is taboo. Thus, the secrecy and feelings of shame surrounding self-inflicted violence are strengthened.

When communication is decreased, feelings of isolation and alienation, the same feelings which often precede an act of self-injury, are increased. Not talking about SIV may actually increase the likelihood that the self-injurer will hurt themselves again. Silence makes a very powerful statement.

Talking about self-inflicted violence is essential. Openly discussing SIV helps those who are hurting themselves. By addressing the issues of self-injury, you remove the secrecy which surrounds it and reduce the shame attached. You are encouraging a connection between you and the self-injurer. The mere fact that you are willing to discuss SIV helps to create change.

You may not know what to say to the individual who is performing acts of SIV. Fortunately, you don't have to know exactly what to say. By acknowledging that you want to talk, even though you're not sure how to proceed, you are opening the channels of communication.

Here are some questions you might want to use to facilitate the discussion.

- How long have you been hurting yourself?
- Why do you hurt yourself?
- How do you hurt yourself?
- When and where do you usually injure yourself?
- How often do you injure yourself?
- How did you learn to hurt yourself?
- What is it like for you to talk with me about hurting yourself?
- Does it hurt when you injure yourself?
- How open are you about your self-injurious behavior?
- Do you want to change your SIV behavior?
- How can I help you with your SIV?

It is necessary to talk about SIV so that the person who is engaging in these activities feels more supported, less isolated, and more connected. Simply talking about SIV will help to decrease the individual's need for self-injurious behavior.

Be Supportive

Talking is one way to provide support; however, there are numerous other ways to show your support to another. One of the best ways to determine how you can best offer support is to directly *ask* the self-injurer how you might be helpful. In doing so, you might find that your idea of support is vastly different from how others view it. Knowing what kind, and when to offer support, is necessary.

A key component in being supportive is to keep your negative reactions to yourself. This is not to say that you should not, or will not, have judgments or negative reactions to SIV. However, you must conceal these beliefs and feelings while you are being supportive. Later, when you are not offering assistance, you may release and express these thoughts and emotions.

Be Available

Most individuals who injure themselves will not do so in the presence of others. Therefore, the more you are with those individuals who hurt themselves, the less opportunity they will have to inflict self-harm. By offering your company and your support, you are actively decreasing the likelihood of SIV.

Many people who hurt themselves have difficulty recognizing or stating their own needs. Therefore, it is helpful for you to offer ways in which you are willing to help. This will allow your students to know when, and in what ways, they are able to rely on you.

Don't Discourage Self-Injury

Typically, when we are told that we can't or shouldn't engage in a given behavior, it is for a good reason. However, these reasons take on much more meaning and relevance if they are self-determined. The consequences of our behavior help us to determine what we should or should not do. Rules, shoulds, shouldn'ts, dos and don'ts, limit us and restrict our freedom. When we maintain the right to choose, our choices are much more powerful and effective.

> *Individuals who hurt themselves may view their SIV as a positive action, an action which helped them to survive.*

It is both aversive and condescending to tell an individual to not self-injure. As mentioned previously, SIV is a method of coping, and it is often used as a final attempt to relieve emotional distress. Most individuals would choose to not hurt themselves if they could. Although SIV produces feelings of shame, secrecy, guilt and isolation, it continues to be utilized as a method of coping. Because some individuals engage in self-injurious behavior despite the many negative effects is a clear indication of the necessity of this action to their survival.

When you tell someone to stop something, you are inserting a barrier to communication. This barrier will likely increase the secrecy around self-inflicted violence. Even a casual comment indicating that your students should stop hurting themselves, runs the risk of damaging the communication and relationship which exists between you. Self-injurers will continue to injure themselves as long as they need to. Your directives will not change this. However, the amount of secrecy and shame experienced because of these actions might change significantly.

Additionally, some individuals who injure themselves may have an adverse reaction to your demand of cessation. By imposing your limits on others, you are creating an atmosphere for failure. Thus, in order to feel control, some who self-injure will increase their SIV behavior in order to feel as if they have choice and control over these actions.

Although it may be incredibly difficult to witness someone's fresh wounds, it is important that you offer support, and not limits, to that individual.

Recognize the Severity of the Person's Distress

Most people don't self-injure because they are curious about what it would be like to hurt themselves. Instead, most SIV is the result of high levels of emotional distress with few available means to cope. Although it may be difficult for you to recognize and tolerate, it is important to realize the extreme level of emotional pain individuals experience surrounding SIV activities.

Open wounds are a fairly direct expression of emotional pain. One of the reasons why individuals injure themselves is so that they transform internal pain into something more tangible, external, and treatable. The wound becomes a symbol both of intense suffering and of survival. It is important to acknowledge the messages sent by these scars and injuries. An ability to understand the severity of the self-injurer's distress and empathize appropriately will enhance your communication and connection. Do not be afraid to raise the subject of emotional pain. Allow the youth to speak about his/her inner turmoil rather than express it through self-damaging methods.

Talking about self-inflicted violence is essential.

Get Help For Your Own Reactions
At some point in our lives, most of us have had the experience of feeling distressed by our reactions to someone else's behavior. Al Anon and similar self-help groups were created to help the friends and families of individuals dealing with problems of addiction and similar behaviors. At this point in time no such organizations exist for those coping with SIV behavior. However, the basic premise upon which these groups were designed clearly applies to the issue of self-inflicted violence. Sometimes the behavior of others affects us in such a profound manner that we need help in dealing with our reactions. Entering psychotherapy to deal with your responses to SIV is one such way to handle the reactions which you may find to be overwhelming or disturbing. You may also ask friends or colleagues for support or speak with a religious counselor.

In conclusion, dealing with those who self-injure can be tremendously difficult. Your own reactions and responses can make all the difference in helping those who are hurting themselves. Remember, you don't need to be perfect—you just need to be willing to learn, grow, and be honest with yourself and those who you're helping.

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SELF-DESTRUCTIVE BEHAVIOR AND BULIMIA NERVOSA

By Dr. Angela Favaro

In the literature, there is little research on the relationship between impulse-control disorders and bulimia nervosa, but preliminary studies show the likelihood of this association. Among patients with kleptomania, for example, about 11% appear to display bulimic symptoms and a diagnosis of eating disorders is also frequent among compulsive buying patients (17-35%). The relationship between impulsivity and bulimia nervosa does not seem to be exclusively due to the presence of a personality disorder.

Professor J. H. Lacey described a subgroup of bulimic patients who reported more than one type of impulsive behavior, such as alcohol and drug abuse, overdosing, self-cutting, and other self-damaging acts. He hypothesized the presence of a syndrome that he called "Multi-impulsive bulimia," which features a failure to control impulsive behavior.

From a different viewpoint, Professor A. R. Favazza investigated a group of patients who reported self-harming behavior. He hypothesized the existence of what was termed a "repetitive self-mutilation syndrome." This syndrome features the alternation of phases of self-mutilating behavior, and phases of other impulsive behaviors, often eating disorders. Additionally, Favazza defined "compulsive self-injurious behavior" as severe nail biting, skin picking, and hair pulling. These types of behaviors are distinguished from "impulsive self-injury," such as self-cutting and burning.

Suicidality in Bulimia Nervosa

In a study of 495 eating-disordered outpatients we observed that purging bulimics had the highest rate of suicide attempts (21%), impulsive self-injurious behavior (26%), and suicidal ideation (38%). It is interesting to note that about three quarters (77%) of the subjects who reported more than one suicide attempt were purging bulimics. A relationship appears to exist between the severity of the eating disorder and the presence of suicidal acts. Among bulimics, suicide attempters presented more serious psychiatric symptoms. In addition, a connection has been found between the use of more than one purging behavior and the presence of suicide attempts in bulimia nervosa. These findings suggest that self-destructive behavior plays an important role in the bulimic psychopathology.

The established link between the presence of both vomiting and laxative abuse and attempted suicide in bulimia nervosa prompted us to hypothesize a "dimensional" link between self-destructive behavior and purging behavior.

Compulsive and Impulsive Behaviors

The differences between the various types of behavior can only partially be explained from a categorical viewpoint. To describe them, a dimensional model seems more appropriate, because it accounts for the similarities and differences among the various types of behavior. In fact, they all appear to be characterized by irresistible urges to commit the act, mounting tension when the individual attempts to resist, and relief after the act has been committed. However, they differ in regards to the frequency of the behavior, ego-dystonic attitudes, and the presence or absence of a trigger, which are much more common for impulsive acts.

To explain the relationship between impulsivity and compulsivity traits in patient samples, some authors have hypothesized a unidimensional model that consists of a continuum from compulsivity to impulsivity. Others theorize orthogonal models where impulsivity and compulsivity represent separate but often coexistent psychological traits.

A Dimensional Model

We recently investigated the relationship between self-destructive behavior and bulimia nervosa from a dimensional point of view. Since some authors consider eating disorders a form of self-destructive behavior on par with suicide attempts and self-cutting, we included skin cutting or burning, suicide attempts, substance or alcohol abuse, severe nail biting, hair pulling and also purging behavior, such as self-induced vomiting and laxative abuse.

The subjects were 125 patients with bulimia nervosa, diagnosed by DSM-IV criteria. They were evaluated by means of a semi-structured interview and self-report questionnaires, which measured eating and psychiatric symptoms. Ninety bulimic subjects (72%) reported at least one form of self-destructive behavior. Purging bulimics reported a significantly higher rate of suicide attempts and severe nail biting than nonpurging subjects, while self-cutting and hair pulling were similar in the groups. As a first step, we performed a principal components analysis which allowed us to examine the grouping of different kinds of behavior in one or more dimensions, and to study the position of every subject on the dimensions that emerged.

The analysis showed a two-factor solution: hair pulling, severe nail biting and self-induced vomiting loaded on a factor which we called "compulsive self-injurious behavior," while skin cutting or burning, suicide attempts, substance abuse and laxative abuse loaded on another factor that we called "impulsive self-injurious behavior."

These findings have two important implications: first, they support the classification of self-injurious behavior proposed by Favazza; and second, they show that purging behavior belongs to the same dimensions as all the other types of self-injurious behavior.

Some authors consider eating disorders a form of self-destructive behavior on par with suicide attempts and self-cutting.

We classified subjects into four groups using their position on the two dimensions of impulsivity and compulsivity. The first group reported a nil or negative score on both dimensions (NONE); the second group had a positive score on the "impulsive" dimension and nil or negative on the "compulsive" dimension (IMP); the third group, on the contrary, had a nil or negative score on the "impulsive" dimension and a positive score on the "compulsive" dimension (COMP); the fourth group reported positive scores on both dimensions (IMPCOMP).

Compulsive behavior is habitual and repetitive, with greater resistance to an ego-dystonic urge (that is an urge that the subject feels as alien and inappropriate) while impulsive behavior tends to be episodic and gratifying. The impulsive behavior seems to be more ego-syntonic (that is an urge that the subject feels as part of her/himself) and is often triggered by events. The two dimensions are not correlated.

The group of patients who reported impulsive features without compulsive ones (IMP) includes both purging and nonpurging bulimics. In this group, there are all the patients who reported substance or alcohol abuse and many of them reported suicide attempts and self-cutting. This group includes the oldest patients in the whole sample and those with a longer duration of illness, that is the most chronic patients.

The IMPCOMP group (reporting both impulsive and compulsive behaviors) has an even higher rate of suicide attempters (71%) and half of them reported skin cutting or burning, while none reported substance abuse. All patients in this group are purging bulimics. But there are important differences between the IMP and IMPCOMP groups: first of all, patients in the IMPCOMP group are significantly younger and have a shorter duration of illness. In addition, they are significantly more depressed than those of the previous group.

From a clinical point of view, the biggest difference lies in the dropout rates. In our sample, the presence of compulsive features appeared to have a "protective" effect against abandoning treatment. In fact, the two compulsive groups (COMP and IMPCOMP) reported the lowest dropout rates (40% and 29% respectively). For the IMPCOMP group, which reported the lowest rate, this could also be due to the presence of a more severe depression, which increases the need for treatment felt by these patients. The highest dropout rate is in the group with only impulsive features (IMP) at 68%. It is also possible that these two groups of impulsive patients (IMP and IMPCOMP), simply represent two different stages of their illness. In the earlier stages, bulimic impulsive patients might be more compulsive in an attempt to react to their loss of control. They are also more depressed and seem to be more motivated to continue treatment. Later, after a very long duration of illness, they perhaps abandon this attempt and lose motivation. And then again, these two impulsive groups could represent two different types of patients who share impulsivity characteristics but differ on other features. Indeed, since all the patients reporting substance abuse belong to impulsive groups, this last hypothesis is a very likely one.

The two groups with no impulsive features (NONE and COMP) appear to be the most similar: no statistically significant difference emerged between them on psychiatric symptoms and other clinical variables. Besides the presence of compulsive self-injurious behavior, the main differences appeared to be the EDI interoceptive awareness subscale score (which describes the lack of confidence in recognizing and identifying emotions and sensations) and the absence, in the compulsive group, of nonpurging bulimic subjects.

Interoceptive awareness appeared to characterize the subjects who reported self-destructive behavior, regardless of the type. The lack of confidence in recognizing and identifying emotions and sensations of hunger and satiety that has often been described in eating-disordered patients seemed to be significantly related to self-destructive and purging behavior. This association prompted us to hypothesize that self-destructive behavior in eating disorders is not only a "tension release" method used as an alternative to binge eating, but also a way to experience one's body, to seek a sense of reality and identity.

Compulsive self-injurious behavior (hair pulling, severe nail biting, and self-induced vomiting) was, in fact, significantly predicted by obsessionality and a more accentuated lack of interoceptive awareness. On the other hand, impulsive self-injurious behavior (cutting, burning, suicide attempts, and substance and laxative abuse) was predicted by sexual abuse and depression.

Conclusions

Self-destructive behavior appears to have a specific link with bulimia nervosa, and it seems to have impulsive and compulsive dimensions. The dimensional approach allowed us to examine the relationship among different self-destructive behaviors, irrespective of their prevalence in the sample. Our studies confirmed the presence of a subgroup of patients with impulsive features similar to the previously described multi-impulsive bulimia nervosa. Our findings suggest that the presence of compulsive self-injurious behavior among impulsive subjects has a notable clinical impact. Studies on impulsive bulimics should consider the co-occurrence of compulsive features among their samples, since it seems to identify different types of patients or different stages of their illness. In conclusion, among bulimic patients impulsiveness does not appear to be a categorical characteristic; rather, it forms a continuum. We would add that impulsiveness is not the only important dimension in bulimic psychopathology; the importance of compulsive features should not be underestimated.

Dr. Angela Favaro works in the Eating Disorders Unit of the Dipartimento di Scienze Neurologiche e Psichiatriche at Università di Padova, Italy. This article is condensed, with permission, from Favaro, A. & Santonastaso, P. (1998). Impulsive and Compulsive Self-Injurious Behavior in Bulimia Nervosa: Prevalence and Psychological Correlates. *The Journal of Nervous and Mental Disease*, 186(3), 157-165.

UPCOMING TOPICS

Gay, Lesbian, and Bisexual Youth.

Exact estimates of the number of high school youth who self-identify as gay, lesbian, or bisexual are hard to determine. It has been estimated that 9 students in 30 are directly affected by these issues, either by having a gay or lesbian parent, sibling, or relative, or being gay themselves. Gay, lesbian, and bisexual students have shown to have higher rates of suicide and substance abuse, and are disproportionately represented in the street youth population. The February 2001 issue of *The Prevention Researcher* will examine the ways counseling, school, and social service professionals can assist this largely invisible population. This issue will be the first in our expanded 16-page format.

Tobacco Use.

Despite recent declines in cigarette use, according to the most recent Monitoring the Future data, almost a quarter (23.1%) of high school seniors reported daily cigarette use in 1999. Examining use in the past thirty days, 34.6% of the seniors had smoked (35.4% of the males and 33.5% of the females). White 12th graders report the highest cigarette use (40.1% in the past 30 days) compared to 27.3% of the Hispanic seniors and 14.9% of the African-American seniors. The April 2001 issue of *The Prevention Researcher* will focus on adolescent tobacco use, including the effectiveness of various methods for prevention and control.

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Other Future Topics Include

Homeless Youth • Teenage Depression • Involving Parents in Prevention and Intervention

WHY DO PEOPLE ENGAGE IN SELF-INFLICTED VIOLENCE?

People engage in self-inflicted violence for many reasons. These are the most commonly cited reasons, as stated by Dr. Alderman in her book *The Scarred Soul: Understanding & Ending Self-Inflicted Violence* (New Harbinger Press, Oakland, CA, 1997).

RELIEF FROM FEELINGS

One of the most common reasons for self-injuring is to get relief from intense emotions. Many people who self-injure are not able to regulate or control their emotions well. They may find it difficult to identify, express, or release their emotions. They may never have developed the ability to feel and experience emotions as others do, such as crying, yelling, or screaming. People who engage in self-injury commonly report that before the incident they felt isolated, alienated, depressed, and frustrated.

A METHOD OF COPING

Many people use negative coping techniques to feel better. These include using alcohol or other drugs, violent behavior toward others, overeating, smoking, gambling, and self-inflicted violence.

STOPPING, INDUCING, OR PREVENTING DISSOCIATION

Dissociation is a psychological state in which a person experiences an alteration in consciousness, memory, and sometimes, identity. Everyone dissociates to some extent, however, for most people it is fairly mild, such as tuning out someone who is talking to you. Some people use dissociation as a defense mechanism to protect themselves from overwhelming emotional or physical pain. But these dissociative states themselves can become overwhelming. Self-inflicted violence is one method to reduce, prevent, or end a disturbing dissociative state.

EUPHORIC FEELINGS

When a person experiences physical trauma, their body releases endorphins which have effects similar to morphine. During a self-injuring episode, endorphins are released so the self-injurer does not feel the pain associated with the self-injury. Like morphine, these endorphins can become addictive.

PHYSICALLY EXPRESSING PAIN

Many people who self-injure have difficulty expressing emotional pain. At a time when people can't adequately express their emotions, they may turn to self-inflicted violence as a method of expression. The results of this violence (the cuts, bruises, burns), serve as an expression of the internal conflict. Physically expressing emotional pain allows a person to have concrete evidence of intangible or indefinable emotions.

COMMUNICATION

Sometimes self-inflicted violence is used as a form of communication. People who have difficulty expressing their feelings to others verbally, may use self-injury to let those around them know what they are experiencing. Sometimes the violence may be used to carry a symbolic message. For instance, creating scars or wounds to mark a certain occasion.

SELF-NURTURING

Some people use self-inflicted violence as an attempt to make internal wounds external and to nurture and heal these wounds. Once the emotional pain or trauma is made external through self-injury, it is easier to nurture and heal than when it existed only on the emotional level. The gratifying part of self-injury then becomes the self-care which a person can provide afterwards.

SELF-PUNISHMENT

Research shows that many of the people who self-injure were abused as children. As children, they may have been taught that certain behavior, thoughts, or feelings deserved punishment. This lesson follows them into adulthood and may influence the way they treat themselves. Additionally, self-injurers are often over critical of themselves. This internal criticism facilitates their acts of self-injury.

RE-ENACTING PREVIOUS ABUSE

The reasons a self-injurer may re-enact abuse are varied. Some may replicate the abuse so they can feel a sense of control. Some may reenact the abuse as part of post-traumatic stress during a flashback. Some self-injurers may not know why they act out the abuse, but simply feel the need to do so.

ESTABLISHING CONTROL

Like everyone, when a self-injurer's feelings of control are lessened, their emotional and physical discomfort is increased. During these times, self-inflicted violence may be used to decrease the tension and ease psychological or physical discomfort by allowing the person a sense of control.

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RESOURCES

Healthy Place: Self-Injury Community
www.healthyplace.com/Communities/Self_Injury/site/

An online community for people seeking support, information, or friendship. This site includes access to the "Self-Injury Community" e-mail mailing list, transcripts from online conferences, online journals of self-injurers, and access to The Healing Touch web site.

SAFE Alternatives
www.safe-alternatives.com/
1-800-DONTCUT (1-800-366-8288)

SAFE (Self-Abuse Finally Ends) Alternatives is a treatment program, and there is little here for people seeking more online information about self-injury. We are including it because it is the only toll-free phone number we've found for people looking for more information, who don't have web access.

Self Abuse.Com
www.selfabuse.com/

This site is a large list of links related to self-injury. While the links are not annotated, they are grouped into "Coping Skills," "Newsgroups, Message Boards, Discussion Boards, Chat," "Personal Stories," "General Self-Harm Information, Articles," and more. Most of the links were active when we visited. This would be a good starting point for learning more about self-injury.

Self-Injury Information and Resources
www.selfinjury.freeserve.co.uk/

This is a personal web site created by a woman in the U.K. She includes information on self-injury (including common myths and helpful ways to respond), methods for coping with the urge, alternatives she uses instead of self-injury, how to cope with flashbacks, tips about going with a self-injurer to the Emergency Room, and a list of other resources.

Self-Injury: You are not the only one
www.palace.net/~llama/psych/injury.html

This is the self-injury web site most often referenced either on other web sites or in print media. It includes a wealth of information, from a quick primer for those who are unfamiliar with self-injury, to a self-help page for self-injurers who are feeling the impulse. Upfront, this site warns that there is information here that may be a "trigger" for those who self-injure; those pages seem to be well identified. Also included are a number of interactive areas including a chat room, a web board, and access to the Bodies Under Siege e-mail mailing list.

The Cutting Edge
PO Box 20819, Cleveland OH 44120, USA
Rutamaz@aol.com

The Cutting Edge is a print newsletter for "women living with self-inflicted violence." Published quarterly, *The Cutting Edge* is supported solely through donations. It does not appear to have a web presence.

Young People and Self-Harm
www.ncb.org.uk/projects/selfharm.htm

From the National Children's Bureau (NCB) in the U.K. this site is unique because it has a large list of international "Information Resources." None of these resources appear to link off this page, but phone numbers, addresses, and an occasional e-mail address are listed. An online form lets people add their own research/program/practice or other resource to the list. Additionally, the NCB is involved in research on self-injury (ending in December 2000). With any luck, results from this research will be posted on this site.

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FROM THE EDITOR'S P.C.

Dear Colleagues:

I am pleased to send you our third annual Resource Issue from The Prevention Researcher *team.*

In this supplemental issue you will find several fascinating book reviews on topics that are relevant to you and your colleagues in the prevention arena. I'd like to take this opportunity to thank our reviewers John de Miranda, Ed.M.; Linda M. Espinosa, Ph.D.; and Donna Scott Tilley, RN.

Additionally, you will find Web site reviews on topics we have covered in past issues of The Prevention Researcher, *many upcoming conferences which might interest you, and a cumulative subject index for every article we have published.*

The Resource Issue is our way of keeping you up to date on the topics we have covered in the past. We hope you will give us feedback on our selection of material so we can fine-tune it to meet your needs. Please note on your calendar that our next issue will be mailed in early February 2001. This next issue will be the first of our new sixteen page format. The topic will be on lesbian, gay and bisexual youth.

As always, check out our web site for our latest news, references, abstracts, a complete subject index, and links to hundreds of online resources which we have reviewed.

All the best,

Steven Ungerleider, Ph.D.
Psychologist/Editor

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BOOK REVIEW

CULTURAL DIVERSITY AND SOCIAL SKILLS INSTRUCTION: UNDERSTANDING ETHNIC AND GENDER DIFFERENCES

BY GWENDOLYN CARTLEDGE, PH.D. WITH CONTRIBUTIONS BY JOANNE FELLOWS MILBURN, PH.D.

Reviewed by Linda M. Espinosa, Ph.D.

1996. Champaign, IL: Research Press.
ISBN 0-87822-355-X

This comprehensive volume addresses a major challenge facing U.S. educators and teacher preparation programs—the ability of a largely white European American teaching force to design culturally relevant social skills instruction for racially and ethnically diverse students. As the students we teach and the families they are raised in become increasingly non-white and non-English speaking, it is imperative that our profession better understand the cultural and social conditions of ethnic and racial minorities. The social climate of the classroom, the social competence of the students, and the ability of the teacher to promote pro-social development have been linked to school success and adult competence. This book tackles these issues in a fair, comprehensive, and thoroughly researched manner.

The changing demographics of our classrooms, the disproportionate failure rates of culturally and linguistically diverse students, and the future needs of a strong labor force all point to the need and value of this book which very specifically addresses four cultural groups: Asian Americans, African Americans, Native Americans, and Hispanics as well as cultural differences due to gender. It is based on the premise that "the behaviors of young people from culturally diverse populations need to be viewed from a cultural perspective and that instruction should affirm students and empower them to achieve maximally as well as to benefit others" (p7). Cartledge and Milburn have taken the position that direct instruction is preferable to open-ended discussions particularly with initial social skill teaching and for disadvantaged groups with low socioeconomic status or language differences. Additionally, the authors advocate for cooperative learning approaches that are consistent with the collectivistic roots of the populations included for consideration. With these two premises clearly stated early on in the Introduction, the authors go on to carefully review the historical, cultural, social, and family conditions of each group with instructional recommendations and examples. The intent is to first lay the foundation for a deeper understanding of the values and norms of each group so as to more accurately interpret the behaviors of the diverse students and then to provide concrete suggestions about effective social instruction that is culturally responsive and academically useful. This is an important and ambitious goal that succeeds on most levels.

In Chapter 1, "The Relationship of Culture and Social Behavior," the authors illustrate the deep connections between social behaviors and cultural background. The role of the family and the school in transmitting cultural values, beliefs, and social attitudes and behavior patterns is clearly described. They point out that, "culturally different behaviors are not equivalent to social skill deficits or behavior disorders." Unfortunately, many minority youth have been unfairly misidentified and subjected to inappropriate interventions because of bias or misperceptions. In order to accurately understand the meanings of students' confusing behaviors and effectively teach social skills, teachers need to develop deeper, more realistic understandings about their students' cultural backgrounds. One particular study reviewed highlighted the tendency of teachers to perceive ethnically diverse students in stereotypical ways that are not always consistent with other assessments of the students. This mismatch between the child's reality and the teacher's understanding can lead to misdiagnosis and damaging consequences for students *and* teachers. The central points in this chapter echo the work of Lisa Delpit, Shirley Brice Heath and Courtney Cazden who all eloquently argue for a more culturally knowledgeable and culturally responsive pedagogy.

> The authors illustrate the deep connections between social behaviors and cultural background.

Chapter 2, "A Model for Teaching Social Skills," presents an overview of effective social skills assessment and instruction. The authors start with the importance of defining social skills and targeting appropriate social skills that will be valued by both peers and adults. They offer several methods of assessing social skills including observation, checklists, rating scales, self-report measures, and sociometric procedures. This section could have been more useful if it had also included a fuller discussion of the limitations of some of these approaches with culturally and linguistically diverse students, especially very young children. The chapter goes on to describe the major social skills instructional approaches: direct instruction, modeling, rehearsal, behavior generalization, and cognitive problem-solving instruction. Cooperative learning techniques are emphasized as being particularly appropriate for the diverse populations addressed in the book. The main shortcoming in this chapter is the lack of any discussion about *if* and *when* a particular student might need or benefit from a social skills intervention and how to match specific approaches with particular problems.

Consideration of specific cultural groups is the focus of Chapters 3-6: Asian Americans, African Americans, Native Americans, and Hispanic Americans. I found valuable information about each cultural group, shedding light on the cultural distinctions within and across each group without falling into over-generalizations or cultural stereotyping. When contrasting cultural values and practices it is easy to form simple descriptives when the reality is far more complex. This book is careful to present the intra-cultural variations found within groups and explain the multiple influences on any particular family or subgroup.

* * *

> These chapters provide vivid presentations of material on cultural diversity and social skill teaching that is a must-read for all teachers and administrators.

* * *

I especially liked the emphasis on teaching valuable lessons through culturally representative literature. Many excellent examples of appropriate socio-moral books and teaching strategies are presented. Unfortunately only two of these chapters, Chapter 3 on Asian Americans and Chapter 4 on African Americans, include information on parent and family involvement. Otherwise, these chapters provide vivid presentations of material on cultural diversity and social skills teaching that is a must-read for all teachers and administrators. I plan on incorporating some of the chapters into a graduate class that I teach on Parent/Family Involvement; all prospective and practicing teachers need to develop deeper understandings about what it means to be a young person of color struggling to adapt and succeed in a schooling system based predominately on white middle-class values and norms.

ABOUT THE AUTHORS

Gwendolyn Cartledge, Ph.D. is a professor in the College of Education at Ohio State University; JoAnne Fellows Milburn, Ph.D., currently works in the field of child advocacy and child abuse prevention, after serving on the faculty of the College of Social Work at Ohio State University.

The reviewer, Linda Espinosa, Ph.D., is an associate professor at the University of Missouri, Columbia. Previously, she worked in the public schools as a teacher, principal, and program director for nearly 20 years.

Health Resources Online

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WEB RESOURCES*

These Web sites and all others which we have reviewed in previous issues of The Prevention Researcher *are accessible through our web site at* ***www.TPRonline.org.***

COMMUNITY-BASED PREVENTION

Fighting Back
www.fightingback.org

According to its Web site, "The Fighting Back Project was created by the Robert Wood Johnson Foundation to test the hypothesis that a broad collaboration of community elements could develop a central strategy to harness and focus their collective resources to significantly reduce their most serious substance abuse problems." This site highlights the seven cities/programs in which this project is working, discusses the three elements which continue to show themselves as being useful (leadership, linkages, and local data), and provides a "resource center." The resource center includes top stories in the news, funding news, links to other sites, and "facts." The resource center appears to be supplied solely by "Join Together Direct" which is also funded by the Robert Wood Johnson Foundation.

High-Risk Youth: Here's Proof Prevention Works
www.health.org/features/hry

From the folks at The National Clearinghouse for Alcohol and Drug Information, this site outlines seven science-based model programs that have demonstrated effective strategies for preventing substance use among young people who are at a high risk for alcohol, tobacco and illicit drug use. These seven programs include 1) Across Ages, 2) Child Development Project (CDP), 3) Creating Lasting Connections (CLC), 4) Dare to Be You, 5) Residential Student Assistance Program (RSAP), 6) SMART Leaders, and 7) Family Advocacy Network (FAN Club).

A Toolkit for Hispanic/Latino Community Groups
English:
www.health.org/initiatives/hisplatino/community/toolkiteng.htm
Spanish:
www.health.org/initiatives/hisplatino/community/toolkitspan.htm

This toolkit is an effort to help Hispanic/Latino community groups organize around the problem of drug and alcohol use among youth. The site includes a fact sheet on substance use in the Hispanic/Latino community, factors (risk and protective) which are related to substance use and abuse, protective and risk factors in the Hispanic/Latino community, ways in which community members can help, models for organizing and building successful prevention programs, and developing prevention programs.

DROPOUT PREVENTION

Latina High School Leaving: Some Practical Solutions
www.ed.gov/databases/ERIC_Digests/ed423096.html

By the Educational Resources Information Center (ERIC), this digest explores gender roles, family, school, and peer influence which influence Latinas in their educational and career decisions. Also included are steps which schools and communities can take to make Latinas feel more welcomed. It was originally published in May 1998.

National Dropout Prevention Center/Network
www.dropoutprevention.org

This Web site, by the National Dropout Prevention Center, includes a wealth of information, including a list of fifteen effective strategies which make a positive impact on the dropout rate. This list was under construction when we visited. However, each strategy will include an overview, a list of publications produced by the Center, resources, model programs, and links to key organizations involved in the strategy. Also included on this Web site is a searchable database of model programs, featured articles, "stats and facts," and opportunities for professional development (such as conferences and workshops).

The Urban Institute
www.urban.org

The Urban Institute provides a variety of online reports, two that deal with dropout prevention include *High School Employment: Meaningful Connections for At-Risk Youth* (at www.urban.org/education/appam4b.htm), and *Helping Disconnected Youth by Improving Linkages Between High Schools and Careers* (at www.urban.org/pubs/disconec.htm).

EATING DISORDERS

American Anorexia/Bulimia Association (AA/BA)
www.aabainc.org

The American Anorexia/Bulimia Association (AA/BA) provides an attractive and easy-to-use Web site. The AA/BA offers easy-to-read information about anorexia nervosa, bulimia nervosa, and binge-eating disorder such as statistics, danger signs, and medical consequences. Also included is information for sufferers (including how to find a therapist), and for family/friends (including "understanding your limitations," and "what to expect from recovery"). Natalia Zunino, Ph.D. includes an article entitled *Risk Factors in the Development of Eating Disorders* and the site is rounded out with a large list of books for further reading.

**There is a large amount of information available on the World Wide Web. We list these Web sites only as possible starting points on your journey.* The Prevention Researcher *does not control the information presented on these sites and makes no claim as to the accuracy of the content. Inclusion in this list is not an endorsement by* The Prevention Researcher *or its publisher, Integrated Research Services, Inc.*

ANOREXIA: Information and Guidance for Patients, Family, and Friends
users.neca.com/cwildes

This Web page was designed by a woman whose sister recently died from anorexia. Included on this site is a nice blend of this woman's personal story and many links to other information and resources. Topics include males, older victims, athletes, and compulsive overeaters. Access to newsgroups and an email list for victims of eating disorders is also available from this site.

Eating Disorder Referral and Information Center
www.edreferral.com

Access to the real substance of the Eating Disorder Referral and Information Center is reached through the menu system at the bottom of the home page. Not only is there information on Anorexia Nervosa, Bulimia Nervosa, and binge-eating, but also sections on body image, athletes and eating disorders, and food fears. Information is also included for males, fathers, the media, and loved ones, plus links to other resources, and more.

GAMBLING

Connecticut Council on Problem Gambling
www.ccpg.org

The Connecticut Council on Problem Gambling has put its *Prevention Newsletter* online. This newsletter provides the most in-depth look at gambling prevention that we've seen on the Web, including specific strategies aimed at youth. A sampling of articles in the *Prevention Newsletter* include "Prevalence of Youth Gambling," "Building the Capacity of Professionals Working with Youth," "Sports Betting, Youth and the Super Bowl," and "Providing Alternative Activities for Youth - A Prevention Strategy."

The Electronic Journal of Gambling Issues (EJGI)
www.camh.net/egambling

EJGI is an online journal published by the Centre for Addiction and Mental Health in Ontario Canada. The goal of EJGI is to offer an "Internet-based forum for developments in gambling-related research, policy and treatment as well as personal accounts about gambling and gambling behavior." The feature article when we reviewed the site was specifically on youth gambling. The journal is in its infancy with only two issues published so far, but promises to be a wonderful online resource.

The Weekly Addiction Gambling Education Report (*The Wager*)
www.thewager.org

The Wager is a weekly research bulletin published by the Division on Addictions at Harvard Medical School. Publication began in 1996 and archives of all weekly bulletins are available on the site. The newsletter does not focus specifically on youth, but there are a variety of reports available, including "A Minor Problem or a Problem with Minors?," "Back to School: Gambling & Correlates Among University Students," "Varsity Blues: Maladaptive Behavior in Athletes," "Gender-Based & Culture Bound," and "Gambling, Family, and Criminal Behavior," among many others.

GANGS

National Youth Gang Center
www.iir.com/nygc

A project of Office of Juvenile Justice and Delinquency Prevention (OJJDP), the National Youth Gang Center preforms six major tasks, 1) statistical data collection and analysis on gangs, 2) compilation of gang-related legislation, 3) review of gang literature, 4) identification of promising program strategies, 5) coordination of activities of the youth gang consortium, and 6) provision of technical assistance. Available from this site is OJJDP's Youth Gang Series, Surveys, Statistics, and Analysis, a bibliography of gang literature with over 2,000 books, articles and manuscripts, documents outlining a comprehensive approach to youth gangs, and information on youth gang prevention and intervention. Access to the listserv mailing list "GangInfo" is also available.

INTERNET RESOURCES

Advocates for Youth
www.advocatesforyouth.org

Advocates for Youth is "dedicated to creating programs and promoting policies which help young people make informed and responsible decisions about their sexual health." Their popular and informative Fact Sheets are included on their Web site. The Fact Sheets run a gamut of topics including dating violence, gay/lesbian/bisexual youth, gender bias, and peer education, as well as contraceptive use, sexual abuse, and adolescent child-bearing. Also available are their "issues at a glance" and "programs at a glance" series.

National Institute of Mental Health (NIMH)
www.nimh.nih.gov

NIMH provides information for the general public, practitioners and researchers. Included are brochures, information and fact sheets, reports, press releases, and other educational material. Some of this information is available in Spanish. Included is information on phobias, depression, and panic disorders among others. This information is broken down by audience (ie., adolescents, employers) and by topic (for example, depression is divided into bipolar and suicide among other topics). We found two on-line documents under depression/adolescents: *What to Do When a Friend Is Depressed: A Student Guide*, and *Let's Talk About Depression*. Additionally, NIMH provides an interesting online report entitled *Helping Children and Adolescents with Violence and Disasters*. This report includes a brief definition of trauma, how youth react to trauma, and how to help these trauma victims. This Web site is rounded out with a search engine and the ability to order some documents through the mail or via FAX.

School Psychology Resources Online
www.schoolpsychology.net

For psychologists, parents, and educators, School Psychology Resources Online is a database of links on a variety of topics including eating disorders, substance abuse, suicide, and violence, as well as more general topics such as "adolescence" and "mental health."

Texas Youth Commission
www.tyc.state.tx.us

The Texas Youth Commission provides a search engine to a variety of annotated Web links. These links are also available for browsing under "Table of Contents." Topics include violence, substance abuse, youth development, family, and community development, among others. Links are to both private and government organizations.

PREGNANCY PREVENTION

Child Trends
www.childtrends.org

Child Trends is a nonprofit, nonpartisan research organization dedicated to studying children, youth, and families. This site offers several online reports and articles on adolescent sexual behavior in PDF format. These reports include "Reducing Developmental and Cultural Barriers to Reproductive Health Services for Diverse Youth," "Trends in Sexual Activity and Contraceptive Use Among Teens," "Partners, Predators, Peers, Protectors: Males and Teen Pregnancy," and "Next Steps and Best Bets: Approaches to Preventing Adolescent Childbearing." Summaries of other reports are also available.

Teen Wire
www.teenwire.com

Teen Wire is a site for teen girls by Planned Parenthood. It is billed as a place where teens can get information and news about teen sexuality, sexual health, and relationships. The site is colorful, full of quick polls, and entertaining. Included is an "Ask the Experts" column, Frequently Asked Questions (some answered in Spanish), and a "Warehouse" of articles on a variety of topics. Planned Parenthood specifically asks parents and health educators not to participate in the online discussions, they are directed to the Planned Parenthood site (www.plannedparenthood.org).

SCHOOL/GUN VIOLENCE

Blueprints for Violence Prevention
www.colorado.edu/cspv/blueprints

The Blueprints for Violence Prevention Web site provides an overview, details, video clip, and contact information for ten model violence prevention programs which have met a very high scientific standard of program effectiveness. Additionally eighteen promising programs (those which have met some but not all of the effectiveness criteria) are also highlighted. Blueprints also offers an interactive program selection database which allows a user to enter the type of program they are looking for, their target audience, and other searching criteria, and have programs suggested for them. Blueprints is from the Center for the Study and Prevention of Violence (CSPV).

Keep Schools Safe
www.keepschoolssafe.org

A project of the National Association of Attorneys General and the National School Boards Association, the Keep Schools Safe Web site contains information for parents, teachers, school administrators, and law enforcement officers. This site is an attractive interface to other resources on the Web as most of the links will take you off the site. However, these links come from sources such as the PTA, the U.S. Department of Education, NCJRS, the U.S. Department of Justice, and the American Psychological Association.

Pacific Center for Violence Prevention (PCVP)
www.pcvp.org

The Pacific Center for Violence Prevention is located at San Francisco General Hospital. It serves as the policy headquarters for the Violence Prevention Initiative and is funded by The California Wellness Foundation. While PCVP works to prevent youth violence in California its Web site contains information of use to others. The section on firearms provides links to reports and articles put online by other organizations, firearm statistics in the U.S. and California, a variety of online searchable databases, fact sheets, policy briefs, and links to other resources. The section on violence contains many of the same categories.

Safe From Harm: An Online Anthology on School Security
www.asbj.com/security

Developed by the American School Board Association, this is a compilation of articles which appeared in the *American School Board Journal* and other Association publications. All articles appear in their entirety, and new material is added when it becomes available. The Association's goal for the anthology is "to help school leaders understand the roots of youth violence and strategies to prevent it." A sampling of article titles includes: "Breaking the Code of Silence: A school security expert says student silence is our worst enemy," "School Safety: Probing the roots and prevention of youth violence," and "Education in Black & White: How kids learn racism — and how schools can help them unlearn it."

Warning Signs
helping.apa.org/warningsigns
1-800-268-0078

The American Psychological Association and MTV have partnered up "to provide youth with information about identifying the warning signs of violent behavior and how to get help if they recognize these signs in themselves or their peers." The result, besides a 30-minute TV special which appeared on MTV, is an attractive Web site and print brochure. The Warning Signs Web site includes information about why some people are violent, recognizing warning signs of violence in others, what to do if you know someone who is showing these signs, how to deal with anger, and recognizing signs of violence in yourself.

SUICIDE

Youth Suicide Prevention Project
depts.washington.edu/ysp

Developed by the University of Washington, this attractive site was specifically designed for Washington residents. However, it contains information on youth suicide for others as well. Phone numbers for immediate help (including the National Youth Crisis Hotline at 800-448-4663), suicide warning signs, statistics, information on how to help, media guidelines, and teen success stories are all included.

BOOK REVIEW

Angry Young Men: How Parents, Teachers and Counselors Can Help "Bad Boys" Become Good Men

By Aaron Kipnis, Ph.D.

Reviewed by John de Miranda, Ed.M.

1999. San Francisco, CA: Jossey-Bass
ISBN 0-7879-4604-4

Angry Young Men explores our culture's deep ambivalence towards boys, male adolescents, and young men. The book illuminates how and why our major institutions pathologize, demonize, and traumatize these groups and suggests concrete steps that individuals and organizations can take to improve the prospects of youth often categorized as "high risk."

The author, Aaron Kipnis, speaks from both personal and professional experience. As he describes incidents from what he calls his own "violent and incarcerated adolescence" and draws parallels with youth he has known or helped, he shows us the inner workings of the young male psyche and how the difference between a "bad" and "good" boy is often situational or can be traced back to earlier abuse and neglect.

Within the helping professions there is a perpetual debate about the appropriateness of self-disclosure and to what extent personal history shapes our outlook and work. Kipnis holds back little about his past. We learn that his mother was neglectful and abusive, his stepfather beat him, that he spent time in correctional facilities, was a prostitute for a time, and made several suicide attempts. The book is as much a personal memoir-cum-catharsis as an indictment of the various institutions that care for our young males. For Kipnis the personal and experiential are clearly the most important assets that anyone can bring to youth work. He even provides a list of factors that helped him transform his own life, including:

- The attention of older men—teachers, mentors, healers, and social servants—who believed in him and treated him with respect,
- Spiritual experiences, alone and in the community, that raised hope and buoyed him against the downward pull of the past.

In places I found his analysis a bit histrionic and somewhat simplistic. The foster care, mental health, and juvenile justice systems are dismissed as full of poorly trained and abusive caregivers and sadistic correctional staff. His world is divided into the few individuals and programs that truly understand and help kids (perhaps not surprisingly these are the folks who, like Kipnis, have led troubled lives themselves) versus the large and insensitive institutional systems that do little, in his opinion, but exacerbate the problem. When he makes global statements such as, "The government does not collect, evaluate, or disseminate information on the efficacy of most individually-tailored, community-based programs," I wonder about his credentials to make such a judgment.

For example, as someone who is familiar with both federal grant programs and the evaluation literature, I disagree with his assessment about the shortcomings of "the government." The federal government's Center for Substance Abuse Prevention and the Office for Juvenile Justice and Delinquency Prevention are just two examples of bureaucracies that are hugely concerned about and fund efficacy/outcome research and evaluation. Also, my experience with foster care and juvenile justice staff is substantially different from his. I see these workers as well-intentioned and perhaps inexperienced, but doing their best while being under-trained, under-resourced and under-valued.

> The author does a masterful job of blending the statistical facts with vignettes from the lives of real people.

The book's strength is its presentation of the plight of boys and young men who are struggling with their identity and our societal institutions. Here the author does a masterful job of blending the statistical facts with vignettes from the lives of real people including his own. We learn about men like Jeff Prieto, a former gang member, who through his own efforts and those of teachers and counselors attended the University of California and Princeton. Today he is an attorney with the Environmental Protection Agency and works to end barrio violence. Less fortunate was the author's friend, Wayne, who was killed in a car crash transporting three kilos of marijuana. This "accident" resulted in Kipnis' prosecution for marijuana possession, a finding that would haunt him for years as he tried to pull out of his self-destructive path.

The chapter "Drugs and Criminalization" provides a lively discussion of the major issues in reducing drug-related problems. The logic of his investigations cause him to close the chapter with recommendations to eschew "fundamentalist, zero-tolerance propaganda," "adopt harm reduction as the guiding principle of national drug policy," and explore the merits of drug decriminalization. A tall order with little likelihood of implementation.

> The book's strength is its presentation of the plight of boys and young men who are struggling with their identity and our societal institutions

The book succeeds in delineating the landscape of boys at risk and the author's seven paths that can lead to prison (home, school, the street, juvenile institutions, drugs, youth crime and gangs, and the criminal justice system). The analysis falls short, however, in several important areas. Although the author makes much of the fact that public sentiment concerning young males is decidedly negative, the role of the body politic and the media get only passing attention. Both of these institutions are powerful determinants of public opinion, yet none of the recommendations target these larger environmental influences. Like drug users and addicts, boys and young men are easy to demonize. As long as conservative elected and appointed officials can gain political advantage by being tough on crime and using rhetoric such as "super predators," (and as long as we and the media let them get away with it) the situation our young men face will always be precarious.

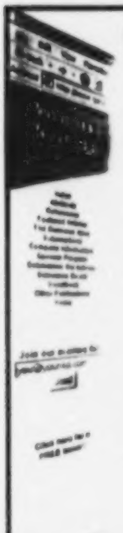
Angry Young Men is engaging and easy to read. It joins a growing body of literature calling attention to the plight of boys and young adult males. Anyone working with male youth will appreciate its insights and be moved by the author's passionate commitment to improving the circumstances of our nation's next cohort of adult men.

The book contains excellent and detailed references for the many sources cited in the narrative, as well as several pp. of electronic resources and a comprehensive index.

ABOUT THE AUTHORS

The author, Aaron Kipnis, Ph.D., is a popular national speaker and consultant on male psychology. He is president of the Fatherhood Coalition and teaches at Pacifica Graduate Institute. He is author of Knights Without Armor, *and co-author of* What Men and Women Really Want.

The reviewer, John de Miranda, is executive director of the National Association on Alcohol, Drugs and Disabilities, Inc., and teaches at the Alcohol and Drug Studies Program at the University of California, Berkeley.



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BOOK REVIEW

EVERYTHING YOU NEED TO KNOW ABOUT DATE RAPE

BY FRANCES SHUKER-HAINES

1998. New York: The Rosen Publishing Group
ISBN 0-8239-2882-9

and

COPING WITH DATE AND ACQUAINTANCE RAPE

BY ANDREA PARROT, PH.D.

1999. New York: The Rosen Publishing Group
ISBN 0-8239-2861-6

Reviewed by Donna Scott Tilley, R.N.

Date and acquaintance rape occurs with alarming frequency. Though rape is a horrifying event for anyone, date rape may be more difficult to cope with because the perpetrator is often a trusted friend. Because date rape is still poorly understood, victims and those who care about them may not know what their legal and counseling options are. The two books reviewed here provide an honest and comprehensive discussion about date and acquaintance rape. While both books are excellent, one is more appropriate for younger readers, while the other is more appropriate for the more mature reader.

Everything You Need to Know About Date Rape is a brief, easy to read book geared to teenagers. It's written in clear, simple terms and uses case studies to illustrate important concepts. The book clearly explains what rape is. Myths about rape are identified and clarified. Social stereotypes and other social factors that can contribute to rape are discussed. The discussion of stereotypes and myths is thought provoking, both in terms of how women and girls think about themselves, as well as what we teach our children about gender roles and women. The author follows the chapter about stereotyping with a chapter about empowerment and self-defense, two very important concepts for young girls who may feel vulnerable and powerless. One of the strengths of this book is the author's discussion about how men and boys can recognize their own behaviors and thinking that may lead to date rape. She also addresses issues men may face when they become rape victims. The book concludes with a clear and concise discussion about what a victim can and should do in the event of a rape and gives straightforward advice to friends of victims and how they can help. A brief glossary at the end ensures that all terms used in the book are easily understood by young readers and a resource page lists helpful hotline numbers and web site addresses. This book is clearly and concisely written and is a wonderful resource for teens who are beginning to date. High school and college-age readers may find it simplistic, but younger teens will appreciate the straightforward way in which this complex topic is addressed.

> Both books are likely to be a valuable resource for victims of date or acquaintance rape.

Coping With Date and Acquaintance Rape is written in frank and simple terms. This book is clearly geared to older teens and college-age men and women. Though it is interesting and informative reading for anyone, it seems to be written for persons who may have been victims of date or acquaintance rape. The book begins with a clear definition of date and acquaintance rape and case studies are used generously to illustrate the key points throughout the entire book. The author discusses how boys and girls are socialized in ways that may promote rape, particularly in dating situations. The problem of alcohol and substance use as it relates to date rape is discussed frequently and in detail including a discussion of the drug Rohypnol and precautions girls can take to avoid contaminated drinks. One of the major strengths of the book is that the author repeats key points frequently—the reader who is flipping through the book or reading selected chapters is likely to get essential content without reading the entire book.

A chapter on athletes and date rape explains how some boys may be more likely to rape because of socialization and messages common to athletes. Coping with the difficult emotions and changes in relationships after rape is covered in depth. The author devotes an entire chapter to explaining how to overcome the myths and stereotypes, as well as realistic ways that individuals can work to reduce rape. There are two chapters devoted to men. One chapter addresses how men can recognize rape if they have committed it, how they can avoid buying into myths about rape, and how they can avoid situations that might lead to rape. The other speaks to men who may have been raped and offers frank discussion about how men can recover from rape. After reading this book, there should be no doubt in the reader's mind about who is at fault when rape occurs. Another major strength of the book is the compassionate and straightforward way the author exonerates victims of any blame when rape occurs.

Comparing and Contrasting Both Books

Everything You Need to Know About Date Rape by Shuker-Haines is clearly more appropriate for the younger reader, while *Coping With Date and Acquaintance Rape* by Parrot is written for high school and college-age readers. Shuker-Haines informs the reader about rape in general, though there are portions that discuss how to cope if rape has already occurred. Parrot spends more time addressing the needs of the reader who has already experienced rape or has a friend who has been raped. Parrot's book is longer and offers more case studies, some of which are a bit graphic. It is also more detailed and addresses more specific questions. For an adult who might be counseling or working with younger victims, reading *Coping With Date and Acquaintance Rape* and sharing selected material from it might be more helpful for younger victims than giving the book to a younger reader.

Both books are very reader friendly, simple to read, and brief. Both address the needs of readers who wish to learn more about rape, deal with a rape that has already occurred, or counsel a friend who has been raped. Both books speak to male readers who may be guilty of rape or who may have been a rape victim. Both books are likely to be a valuable resource for victims of date or acquaintance rape. Teachers, parents, counselors, and friends of victims are likely to find these books to be very helpful as well.

ABOUT THE AUTHORS

Frances Shuker-Haines, author of Everything You Need to Know About Date Rape *is a freelance writer currently living in Ann Arbor, Michigan. She specializes in writing about parenting and child rearing.*

Andrea Parrot, Ph.D., author of Coping With Date and Acquaintance Rape, *is with the Department of Policy Analysis and Management at Cornell University, and is also a Clinical Assistant Professor of Psychiatry at the SUNY Health Sciences Center of Syracuse, New York.*

The reviewer, Donna Scott Tilley, RN, MSN, CRNH is an Assistant Professor at Texas Tech University Health Sciences Center School of Nursing. She is currently completing her doctoral dissertation, which focuses on men who batter intimate partners. Donna serves on the Board of Directors for her local women's protective agency and has done work and research with battered women since 1996.

UPCOMING TOPICS

GAY, LESBIAN AND BISEXUAL YOUTH

Exact estimates of the number of high school youth who self-identify as gay, lesbian or bisexual are hard to determine. It has been estimated that 9 students in 30 are directly affected by these issues, either by having a gay or lesbian parent, sibling or relative, or being gay themselves. Gay, lesbian and bisexual students have higher rates of suicide and substance abuse and are disproportionately represented in the street youth population. The February 2001 issue of *The Prevention Researcher* will examine the ways counseling, school, and social service professionals can assist this largely invisible population.

TOBACCO USE

Despite recent declines in cigarette use, according to the most recent Monitoring the Future data, almost a quarter (23.1%) of high school seniors reported daily cigarette use in 1999. Examining use in the past thirty days, 34.6% of the seniors had smoked (35.4% of the males and 33.5% of the females). White 12th graders report the highest cigarette use (40.1% in the past 30 days) compared to 27.3% of the Hispanic seniors and 14.9% of the African American seniors. The April 2001 issue of *The Prevention Researcher* will focus on adolescent tobacco use, including the effectiveness of various methods for prevention and control.

OTHER FUTURE TOPICS INCLUDE:

- Homeless Youth
- Teenage Depression
- Involving Parents in Prevention and Intervention

CONFERENCES

JANUARY

Seventh Joint National Conference on "Alternatives to Expulsion, Suspension and Dropping Out of School"

January 11-13, 2001

Hyatt Orlando Hotel • Orlando, Florida

This conference will share insights on the causes and problems related to school expulsions, suspensions, and drop-outs, and examine ways to deal with students who are considered delinquent, violent, or dangerous. For more information visit the Safe Schools Coalition Web site at www.ed.mtu.edu/safe or call (800) 537-4903.

4th National Prevention Through Recreation Services School

January 25-27, 2001

Lexington Hotel • Phoenix, Arizona

This conference will be a forum for advancing knowledge about the contributions of recreation programs and services for meeting the needs of children and youth in our communities. While the specific focus will be on children living in high risk environments, many of the issues relate to planning prevention-oriented programs for all children and youth in the community. For more information visit the National Prevention Through Recreation Services School Web site at wwwrpts.tamu.edu/rpts/school2001.htm, email Vivian Gonzales at vgonzale@rpts.tamu.edu, or call (979) 845-7324.

FEBRUARY

National Network for Youth Conference

February 18-21, 2001

Grand Hyatt Hotel • Washington, DC

The conference this year is "Youth + Adults Uniting for Community Change." Attending will be over 1,000 young people and youth advocates from across the nation. There will be over 60 workshops and an exhibits area with a wide variety of displays. For more information contact Giulia Frumendo at (202) 783-7949.

MARCH

Virginia Association of Specialist in Group Work "Group-A-Rama 2001"

March 5, 2001

North Virginia Community College • Annandele, VA

This one-day event will include eighteen workshops and a keynote speaker. For more information contact Barbara Lavine at (703) 645-7016 or Esther Pincus at (703) 913-3832.

17th National Symposium on Child Sexual Abuse

March 13-16, 2001

Huntsville, Alabama

This symposium will provide comprehensive training on child sexual abuse and child maltreatment. Workshops are designed for federal employees, supervisors, law enforcement, educators, child protection workers, juvenile workers, and others. For more information visit the National Children's Advocacy Center Web site at www.ncac-hsv.org/sympo.html or call (256) 534-1328.

School Bus Safety and Management

March 26-27, 2001

Orlando, Florida

This training, by the Comprehensive Health Education Foundation, is designed to prepare K-12 bus drivers to identify, prevent, and respond to negative youth behaviors; to understand their partnership role in supporting the healthy development of their riders; and to proactively address bus safety and management to ensure that all riders arrive at school physically and emotionally ready for their day. For more information visit the Foundation's Web site at www.chef.org, or contact Deborah Pitcock Crawley at (800) 323-2433.

APRIL

13th Annual National Student Assistance Conference (NSAC)

April 4-7, 2001

Hilton Hotel, Walt Disney World Resort

Orlando, Florida

"Effective Programs Mean Student Success" is sponsored by Student Assistance Journal in conjunction with the National Association of Student Assistance Professionals. Keynote speakers are Claudia Black, Tom Jackson and Susan Taylor-Greene. Visit www.nasap.org/national.htm, for more information or call the conference department at (800) 453-7733.

26th Annual Adolescent Sexuality Conference

April 23-24, 2001

Seaside, Oregon

Sponsored by Marion County Health Department, this conference covers a wide spectrum of adolescent sexuality issues, with an emphasis this year on male sexuality. It is also an excellent opportunity to meet and network with others in the field from throughout the Northwest. Approximately 500 attend. Contact Kristin Nelson at knelson@open.org or (503) 373-3751.

The Prevention Researcher is currently accepting articles on the following topics:

Involving Parents In Prevention and Intervention (deadline April 2, 2001)

Mentoring (deadline June 4, 2001)

Please see our Web site (www.TPRonline.org) for more information and submission guidelines.

JUNE

105th Annual National PTA Convention & Exhibition

June 23-26, 2001

Baltimore Convention Center • Baltimore, Maryland

Each year the National PTA Convention and Exhibition serves as an important meeting ground where child advocates convene to work, learn, and share. For more information visit the National PTA Web site at www.pta.org or call (312) 670-6728.

JULY

3rd National Conference on Hispanic/Latino Pediatric Behavioral Health Care

July, 2001

Denton, Texas

Sponsored by the Center for Cross-Cultural Pediatric Behavioral Health, the title of this year's conference is "Cultural Competency: Filling the Gaps Within and Across Pediatric and School Health Environments." The conference goals include providing models of culturally competent services that are developmentally sensitive to Latino children and families, promoting local, state, national and international developments in school and community linked pediatric behavioral health care, and developing an interdisciplinary network of professionals serving Hispanic/Latino children and youth. For more information visit the Center's Web site at www.unt.edu/pediatric or call (940) 369-7759.

6th Annual National Prevention Institute

July 16-17, 2001

San Diego, California

The National Prevention Institute, sponsored by the Comprehensive Health Education Foundation, focuses on critical health issues facing today's youth. The overall goal of the Institute is to strengthen school and community programs that support the healthy development of youth and reduce risk behaviors in the areas of violence, drug abuse, sexuality, intentional and unintentional injury, and dropout and delinquency. For more information visit the Foundation's Web site at www.chef.org, or contact Deborah Pitcock Crawley at (800) 323-2433.

Teens and Drugs

July 19-21, 2001

Grouse Mountain Lodge

Whitefish, Montana

This is the 6th Annual Mental Health Symposium sponsored by Pathways Treatment Center and Kalispell Regional Medical Center in Kalispell Montana. For more information, including a list of keynote speakers, call (406) 752-1775.

SEPTEMBER

6th International Conference on Family Violence: Working Together to End Abuse

September 8-12, 2001

Town & Country Hotel and Convention Center

San Diego, California

A conference for advocates, law enforcement officers, psychologists, counselors, educators, nurses, social workers, and others, the 6th International Conference on Family Violence: Working Together to End Abuse is sponsored by the Family Violence and Sexual Assault institute. More information will be posted on the FVSAI Web site at www.fvsai.org or call (858) 623-2777.

NOVEMBER

American School Health Association/
75th Anniversary National School Health Conference

November 7-11, 2001

Hilton Hotel • Albuquerque, New Mexico

For more information visit the American School Health Association's Web site at www.ashaweb.org, contact Mary Bamer Ramsier at mbramsi@ashaweb.org, or call (330) 678-1601.

NOVEMBER - DECEMBER

13th Annual Conference Federation of Families for Children's Mental Health

November 29-December 2, 2001

Renaissance Hotel • Washington DC

The conference is designed for families of children who have emotional, behavioral or mental disorders and the professionals who work side by side with them. Each year, the conference focuses on topical advocacy and treatment issues affecting children and families. For more information visit the conference Web site at www.bcfamily.com, or call (703) 684-7710.

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